# 114.1 CMR 17.00: REQUIREMENT FOR THE SUBMISSION OF HOSPITAL CASE MIX AND CHARGE DATA

Section
17.01: General Provisions
17.02: Definitions
17.03: Inpatient Data Record Descriptions
17.04: Inpatient Data Record Specifications
17.05: Inpatient Data Element Definitions
17.06: Inpatient Data Code Tables
17.07: Inpatient Data Quality Standards
17.08: Outpatient Observation Data Specifications
17.09: Data Submission Requirements
17.10: Submission Dates
17.11: Compliance
17.12: Protection of Confidentiality of Data
17.13: Severability
17.14: Administrative and Technical Information Bulletins
17.15: Outpatient Emergency Department Visit Data

## 17.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.1 CMR 17.00 establishes the requirement that each general acute hospital provide to the Division of Health Care Finance and Policy (DHCFP) data describing the case mix of its patients and the charges for services provided these patients, such data to be utilized in establishing reasonable and adequate rates, for grouping hospitals and comparing costs, to assist in the formulation of health care policy, and to assist in the provision and purchase of health care services.

Hospitals will file inpatient and outpatient observation case mix and charge data using the specifications set forth herein, starting with the reporting period that begins October 1, 2001. Inpatient and outpatient observation case mix and charge data for reporting periods ending September 30, 2001 or earlier shall be governed by the version of 114.1 CMR 17.00 in effect on the last day of the reporting period.

Hospitals will file outpatient emergency department visit case mix and charge data using the specifications set forth herein and in administrative bulletins issued under 114.1 CMR 17.15, starting with the reporting period that begins October 1, 2001. Hospitals also will file outpatient emergency department visit case mix and charge data for prior periods as described in 114.1 CMR 17.15(3). For purposes of 114.1 CMR 17, outpatient emergency departments include both the on-campus department of the hospitals that provides emergency services and any satellite emergency facilities on the hospital's license as defined in 105 CMR 130.820.

2) Authority. 114.1 CMR 17.00 is adopted pursuant to M.G.L.c. 118G.

## 17.02: Definitions

As used in 114.1 CMR 17.00 unless the context clearly requires otherwise, the following words shall have the following meanings:

**Ancillary Services**. The services and their definitions as specified in the HURM. Reporting codes are defined in 114.1 CMR 17.06(2)(c).

**Case Mix Data**. Case specific, diagnostic discharge data which describes socio-demographic characteristics of the patient, the medical reason for admission or visit, treatment and services provided the patient and duration and status of the patient's stay in or visit to the hospital. Case mix

data refers to a slightly modified version of the UB-92 data set and shall include, but not be limited to, the data elements specified in 114.1 CMR 17.04, 17.05, and 17.08, and, for outpatient emergency department visit data, the data elements described in 114.1 CMR 17.15 and specified in technical and data specifications issued by administrative bulletin pursuant to 114.1 CMR 17.15.

**Charge Data**. The full, undiscounted total and service specific charges billed by the hospital to the general public as defined in M.G.L.c.118G. Charge data shall include, but not be limited to, the UB-92 data elements and codes specified in 114.1 CMR 17.04, 17.05, 17:08 and, for outpatient emergency department visit data, the data elements described in 114.1 CMR 17.15 and specified in technical and data specifications issued by administrative bulletin pursuant to 114.1 CMR 17.15.

**CPT**. Current Procedural Terminology is a coding system used to describe medical procedures and services, developed and maintained by the American Medical Association. CPT codes and descriptions only are copyrighted by the American Medical Association.

**DHCFP.** The Commonwealth of Massachusetts Division of Health Care Finance and Policy.

**Division**. The Division of Health Care Finance and Policy established under M.G.L.c.118G.

**Elective Admission**. The admission of a patient who is neither an emergency, urgent or newborn admission.

**Emergency Admission**. The admission of a patient who requires immediate medical intervention without which life, loss of limb or permanent impairment or disfunction is threatened.

**Emergency Department (ED)**. The department of a hospital, or health care facility off the premises of a hospital that is listed on the license of the hospital and qualifies as a Satellite Emergency Facility under 105 CMR 130.820 through 130.836, that provides emergency services as defined in 105 CMR 130.020. Emergency services are further defined in the HURM, Chapter III, s. 3242.

**Emergency Department Visit**. Any visit by a patient to an emergency department which results in registration at the ED but does not result in an outpatient observation stay nor the inpatient admission of the patient at the reporting facility. An ED visit occurs even if the only service provided to a registered patient is triage or screening. An ED visit is further defined in the HURM Chapter III, s. 3242**.**

**General Acute Care Hospital**. A facility licensed under M.G.L.c. 111, ss. 51 through 56 and classified under those sections as:

(a) a general hospital with maternity service, or
(b) a general hospital without maternity service, or
(c) a pediatric hospital.

Also included are the hospitals of the University of Massachusetts Medical Center, the Dana-Farber Cancer Institute, and the Massachusetts Eye and Ear Infirmary.

**HCPCS.** The HCFA Common Procedure Coding System.

**HURM.** The Hospital Uniform Reporting Manual promulgated as part of the Division's regulation 114.1 CMR 4.00.

**ICD-9-CM Coding System**. The United States version of the International Classification of Diseases - Clinical Modification coding system recommended for coding diagnoses and procedures by the U.S. Health Care Financing Administration, Department of Health and Human Services.

**Medical Record Number**. The unique number assigned to each patient within the hospital that distinguishes the patient and the patient's hospital record(s) from all others in that institution.

**Observation Services**. Those services furnished on a hospital's premises which are reasonable and necessary to further evaluate the patient's condition and provide treatment to determine the need for possible admission to the hospital. These services include the use of a bed and periodic monitoring by a hospital's physician, nursing and other staff. Observation services are further defined in the HURM s. 3241, except for the unit of measure which is reported in hours for the Case Mix Data.

(a) *Inpatient Observation Services.* If the patient is admitted, observation services are considered inpatient observation services and should be included with the inpatient's discharge record and reported as specified in 17:05 (3)(e),17:05 3(g), and 17:06(2)(c).

(b) *Outpatient Observation Services.* If the patient is not admitted, observation services are considered outpatient observation services and should be reported with the Outpatient Observation Data as specified in 17.08.

**Routine Services**. The services and their definitions as specified in the HURM s. 3241, promulgated under 114.1 CMR 4.00. Reporting codes are defined in 114.1 CMR 17.06(2)(a).

**Special Care Units**. The units which provide patient care of a more intensive nature than provided to the usual medical, obstetric or pediatric patient. These units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who require intense comprehensive care. Special care units shall include, but not be limited to, those units specified in 114.1 CMR 17.06(2)(b).

**UB-92**. The current version of the uniform bill, composed of a data set negotiated by the National Uniform Billing Committee, to be used by major third party payers and most hospitals, hospital-based skilled nursing facilities and home health agencies.

**Units of Service**. Units of Service shall be reported according to the HURM, except where otherwise noted in 17:05 (4), 17:05 (5), 17:06 (2), and 17.08(1), or for outpatient emergency department visit data, in technical and data specifications issued by administrative bulletin pursuant to 114.1 CMR 17.15.

**Urgent Admission**. The admission of a patient who does not require immediate medical/surgical intervention but does require admission within two weeks.

## 17.03: Inpatient Data Record Descriptions

(1) 114.1 CMR 17.03 contains the data record descriptions for the magnetic tape submissions of merged case mix and billing. In the future, the Division may allow for submission of data by other media types or varying modes of data submission. The record specifications, data elements definitions, and code tables appear in 114.1 CMR 17.04, 17.05, and 17.06 respectively.

(2) **Patient Discharge Records**:

Each patient discharge will be represented by six record types as follows:

| | | |
|---|---|---|
| | **Record Type '20'** | Record Type '20' contains selected socio-demographic and clinical information pertaining to the discharged patient. This record is presented once for each patient discharge in the reporting period. |
| b) | **Record Type '30'** | *Record Type '30'* summarizes the charges billed and the units of service (days) provided in routine and special care accommodations for each patient discharge. This record may be repeated more than once per discharge if it is necessary to report the use of more than five different routine and/or special care accommodations within this episode of care. |

| | | |
|---|---|---|
| c) | **Record Type '40'** | *Record Type '40'* summarizes the charges billed and the units of service provided for prescribed ancillary revenue centers. This record may be repeated more than once per discharge if it is necessary to report the use of more than five different ancillary services within this episode of care. |
| d) | **Record Type '50'** | *Record Type '50'* reports diagnosis and additional clinical information pertaining to this patient's episode of care. This record is provided once for each patient discharge. |
| e) | **Record Type '60'** | *Record Type '60'* reports procedures and additional clinical information pertaining to this patient's episode of care. This record is provided once for each patient discharge. |
| f) | **Record Type '90'** | *Record Type '90'* is a control record which balances the counts of each of the several discharge specific records and charges. This record is provided once per patient discharge. |

(3) **Tape Submission Records**.

Tape submission(s) must also contain four other types of records as follows:

| | | |
|---|---|---|
| | **Record Type '1'** | *Record Type '1'* is the first record appearing on the tape and occurs only once per submission. This label record identifies the tape submitter which may be an individual hospital or a processor submitting data for one or more hospitals. If the submitter provides data on multiple tapes, this record is reported only once as the first record of the first tape. |
| b) | **Record Type '10'** | *Record Type '10'* identifies each hospital whose data is provided on the tape. This record is repeated for each individual hospital included on the tape and is the first record of each provider's batch. See batch type codes in 114.1 CMR 17.06. |
| c) | **Record Type '95'** | *Record Type '95'* is a control record which balances selected data from all patient discharges for each individual hospital batch and is the last record of the provider batch. See batch type codes in 114.1 CMR 17.06. |
| d) | **Record Type '99'** | *Record Type '99'* is a control record which balances the number of hospital batches provided in this particular submission. On this record the value for field number 4, 'Number of Providers on tape(s),' and field number 6,' Count of Batches' should be equal. When more than one batch per hospital is submitted on a single tape, each batch will be treated as if it came from a different hospital, providing they are different batch types and/or cover different reporting periods. Identical batches submitted for the same provider will cause rejection of both batches. This is the last record of the submission. If the submitter is providing data on multiple tapes, this is the last record of the last tape. |

## 17.04: Inpatient Data Record Specifications

These specifications have been modified from those described in the original 114.1 CMR 17.00. The Division has attempted to minimize any re-programming your hospital or processor will have to undertake to comply with both current DHCFP requirements and any expansions in the

future.

The record specifications contain more data elements than are required by the Division of Health Care Finance and Policy. *Those data elements which are marked with an asterisk indicate those data elements which are part of the error checking process described in 114.1 CMR 17.07 and they must be provided*. Though the non-asterisked data elements are not required by the Division of Health Care Finance and Policy, it is acceptable to report them. It is advisable to reserve non-asterisked fields for the data elements described in the tape specifications; these reserved fields will permit the expansion of the elements captured and reported in the future with little or no additional programming.

The physical specification of the magnetic tape shall be any size reel of unlabeled magnetic tape recorded in nine track, EBCDIC mode with a density equal to 1600 or 6250 BPI. The logical record length must be 250 characters with a blocking factor of ten.

The edit specifications are incorporated into the Division's system for receiving and editing incoming data tapes. The Division recommends that data processing systems incorporate these edits to minimize:

(a) the potential of unacceptable data reaching the Division and

(b) penalties for inadequate compliance as specified in 114.1 CMR 17.11.

(1)

Record Name = Label
Record Type = 01
Record No. = 1

| | Field Name | Pic-ture | Spec. | Field Position From-Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '01' | XX | L/B | 1 2 | - Must be first record on tape |
| *2 | Submitter EIN | X(10) | L/B | 3 12 | - Must be present<br>- Must be numeric |
| *3 | Submitter Name | X(18) | L/B | 13 30 | - Must be present |
| 4 | Filler | X | | 31 31 | |
| *5 | Receiver Identification | X(5) | L/B | 32 36 | - Must be present |
| 6 | Filler | X(4) | | 37 40 | |
| *7 | Processing Date (CCYYMMDD) | X(8) | L/B | 41 48 | - Must be present<br>- Must be valid date<br>- Must not be later than today's date |
| 8 | Filler | X(57) | | 49 105 | |
| *9 | Reel Number | 99 | R/Z | 106 107 | - Must be numeric<br>- Must be present |
| 10 | Filler | X(143) | | 108 250 | |

(2)

Record Name = Provider
Record Type = 10
Record No. = 2

| | Field Name | Pic-ture | Spec. | Field Position From - Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '10' | XX | L/B | 1 2 | - Must be first record following Label |

| | | | | | Record Type '01' |
|---|---|---|---|---|---|
| *2 | Type of Batch | XX | L/B | 3 4 | -Must be present and valid code as specified in 114.1 CMR 17.06(4) |
| *3 | Batch Number | XX | L/B | 5 6 | - Must be present<br>- Must be numeric |
| 4 | Filler | X(52) | | 7 58 | |
| *5 | MDPH Hosp. Computer No. | X(4) | L/B | 59 62 | - Must be present<br>- Must be numeric<br><br>- Must be valid code in as specified in Attachment I |
| 6 | Filler | X(7) | L/B | 63 69 | |
| *7 | Provider Telephone No. | X(10) | L/B | 70 79 | - Must be present |
| *8 | Provider Name | X(18) | L/B | 80 97 | - Must be present |
| *9 | Provider Address | X(18) | L/B | 98 115 | - Must be present |
| *10 | Provider City | X(15) | L/B | 116 130 | - Must be present |
| *11 | Provider State | XX | L/B | 131 132 | - Must be present |
| *12 | Provider Zip | X(9) | L/B | 133 141 | - Must be present |
| 13 | Filler | X | | 142 142 | |
| *14 | Period Starting Date (CCYYMMDD) | X(8) | L/B | 143 150 | - Must be present<br>- Must be valid date |
| *15 | Period Ending Date (CCYYMMDD) | X(8) | L/B | 151 158 | - Must be present<br><br>- Must be valid date<br><br>- Must be later than Starting Date |
| 16 | Filler | X(92) | | 159 250 | |

(3)

Record Name = Discharge
Record Type = 20
Record No. = 3

| | Field Name | Pic-ture | Spec. | Field Position From - Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '20' | XX | L/B | 1 2 | - Must be first record following Provider Record Type '10' or follow Patient Control Record Type '90' |
| *2 | Medical Record Number | X(10) | L/B | 3 12 | - Must be present |
| *3 | Patient Sex | X | | 13 13 | - Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(a) |
| *4 | Patient Race | X | | 14 14 | - Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(b) |
| *5 | Patient Birthday (CCYYMMDD) | X(8) | L/B | 15 22 | - Must be present<br>- Must be valid date except 99 is acceptable in month & day fields<br>- Must not be later than date of |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | admission |
| 6 | Marital Status Code | X | | 23 23 | - If present must be valid code as specified in 114.1 CMR17.06(1)(c) |
| *7 | Patient Employer Zip Code | 9(9) | L/B | 24 32 | - Must be present, if applicable<br>- Must be numeric |
| *8 | Type of Admission | X | | 33 33 | - Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(d) |
| *9 | Primary Source of Admission | X | | 34 34 | - Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(e)<br>- If the Source of Admission is Observation, code 'X', observation room charges must be present in the Observation Ancillary Revenue Code 762. |
| *10 | Secondary Source of Admission | X | | 35 35 | - Must be present, if applicable<br>-Must be valid code as specified in 114.1 CMR 17.06(1)(e)<br>- If the Source of Admission is Observation, code 'X', observation room charges must be present in the Observation Ancillary Revenue Code 762. |
| *11 | Patient Zip Code | 9(9) | L/B | 36 44 | - Must be present<br>- Must be numeric<br>- Must be a valid zip code<br>- Must be 0's if zip code is unknown<br>- Must be 7's if foreign zip code |
| *12 | Admission Date (CCYYMMDD) | X(8) | L/B | 45 52 | - Must be present<br>- Must be valid date |
| *13 | Discharge Date (CCYYMMDD) | X(8) | L/B | 53 60 | - Must be present<br>- Must be valid date<br>- Must be greater than or equal to admission date<br>- Must not be earlier than Period Starting Date from Provider Record |
| *14 | Veterans Status | X | L/B | 61 61 | - Must be present<br>- Must be a valid code as specified in 114.1 CMR 17.06(1)(i) |
| *15 | Primary Source of Payment | X(3) | L/B | 62 64 | - Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(h)<br>- If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment.<br>- Must be compatible with Primary Payer Type as specified in table in 114.1 CMR 17.06(1)(g) |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | - Must not be a Supplemental Payer Source as specified in 17.06(1)(h) |
| *16 | Patient Status | XX | L/B | 65 66 | - Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(f) |
| *17 | Billing Number | X(17) | L/B | 67 83 | - Must be present<br>- First digit must not be blank<br>-- May include alpha, numeric slash (/) or dash (-), but no special characters. |
| *18 | Primary Payer Type | X | | 84 84 | - Must be present<br>- Must be valid as specified in 114.1 CMR 17.06(1)(g)<br>- Must be compatible with primary source of payment as specified in tables in 114.1 CMR 17.06(1)(h)<br>- If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment. |
| *19 | Claim Certificate Number | X(10) | L/B | 85 94 | - Must be present if primary or secondary Payer Type Code is "4" (Medicaid) or "B" (Medicaid Managed Care) as specified in 114.1 CMR 17.06(1)(g)<br>- Must be blank if neither primary nor secondary payer is Medicaid or Medicaid Managed Care<br>- First position must not be blank if the field contains data<br>- May include alpha, numeric slash (/) or dash (-), but no special characters |
| *20 | Patient Social Security Number | X(9) | L/B | 95 103 | - Must be present<br>- Must be valid social security number or '000000001' if unknown |
| *21 | Birth Weight-grams | 9(4) | R/Z | 104 107 | - Must be present if type of admission is 'newborn'<br>- Must be present if type of admission is other than 'newborn' and age is less than 29 days.<br>- Must not be present if type of admission is other than 'newborn' and age is 29 days or greater<br>- Must be numeric<br>- Must be less than 7300<br>- Must be greater than 0 |
| *22 | DNR Status | X | L/B | 108 108 | - May be present<br>- Must be valid as specified in 114.1 CMR 17.06(1)(j) |

| | | | | | |
|---|---|---|---|---|---|
| 23 | Filler | X(4) | | 109 112 | |
| *24 | Secondary Payer Type | X | | 113 113 | - Must be present<br>- Must be valid as specified in 114.1 CMR 17.06(1)(g)<br>- Must be compatible with secondary source of payment as specified in tables in 114.1 CMR 17.06(1)(h)<br>- If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment.<br>- If not applicable, must be coded as “N” as specified in 114.1 CMR 17.06 (1)(g) for Payer Type and “159” as specified in 17.06(1)(h) for Payer Source. |
| *25 | Secondary Source of Payment | X(3) | L/B | 114 116 | - Must be present if secondary payer type is other than "N"<br>- If Medicaid is one of two payers, Medicaid must be coded as the secondary type and source of payment unless Free Care is the secondary type and source of payment.<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(h)<br>- Must be compatible with secondary Payer Type as specified in tables 114.1 CMR 17.06(1)(g) |
| *26 | Mother’s Social Security Number | X(9) | L/B | 117 125 | - Must be present for newborn or if age less than 1 year<br>-Must be a valid social security number or ‘000000001’ if unknown |
| *27 | Mother’s Medical Record Number | X(10) | L/B | 126 135 | - Must be present for newborns, born in the hospital |
| *28 | Facility Site Number | X(4) | L/B | 136 139 | - May be present |
| *29 | Primary National Payer Identification Number | X(9) | L/B | 140 148 | - May be present when available |
| *30 | Secondary National Payer Identification Number | X(9) | L/B | 149 157 | -May be present when available |
| *31 | ED Flag | X | L/B | 158 158 | - Must be present<br>- Must be a valid code as specified in 114.1 CMR 17.06(1)(k) |
| *32 | Outpatient Observation Stay Flag | X | L/B | 159 159 | - Must be present<br>- Must be a valid code as specified in 114.1 CMR 17.06(1)(l) |
| *33 | Filler | X(91) | | 160 250 | |

(4)

Record Name = IP Accommodations
Record Type = 30
Record No. = 4

| Field No. | Field Name | Pic-ture | Spec. | Field Position From - Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '30' | XX | L/B | 1 2 | - Must be first record following Discharge Record Type '20' or must follow previous Record Type '30' |
| *2 | Sequence | 99 | R/Z | 3 4 | - Must be numeric<br>- If first record following Discharge Record Type '20' sequence must ='01'<br>- For each subsequent occurrence of Record Type '30' sequence must be Incremented by one.<br>- Accumulate count for balancing against Record Type 3x Count field in Patient Control Record Type '90' |
| *3 | Medical Record Number | X(10) | L/B | 5 14 | - Must be present<br>- Must equal Medical Record number from Discharge Record Type '20' |
| 4 | Filler | X(7) | | 15 21 | |
| | ACCOMMODATIONS 1♦ | X(33) | | 22 54 | |
| *5 | Revenue Code (Accommodations) | X(3) | L/B | 22 24 | - If present must be valid code as specified in 114.1 CMR 17.06(2)(a) and (b)+ |
| 6 | Filler | X(5) | | 25 29 | |
| *7 | Unit of Service (Accom. Days) | X(5) | R/Z | 30 34 | - Must be present if related Revenue Code is present |
| 8 | Filler | X | | 35 35 | |
| *9 | Total Charges (Accom.) | 9(6) | R/Z | 36 41 | - Must be present if related Revenue Code is present<br>- Must exceed one dollar<br>- Accumulate Total Charges (Accom.) for balancing against Total Charges (All Charges) in Patient Control Record Type '90' |
| 10 | Filler | X(13) | | 42 54 | |
| *11 | Accommodations 2++ | X(33) | | 55 87 | - May only be present if Accommodations 1 present+<br>- Same as Accommodations 1 |
| *12 | Accommodations 3++ | X(33) | | 88 120 | - May only be present if Accommodations 2 present+<br>- Same as Accommodations 1 |
| *13 | Accommodations 4++ | X(33) | | 121 153 | - May only be present if Accommodations 3 present+<br>- Same as Accommodations 1 |
| *14 | Accommodations 5++ | X(33) | | 154 186 | - May only be present if Accommodations 4 present+<br>- Same as Accommodations 1 |
| *15 | Leave of Absence Days | 9(3) | R/Z | 187 189 | - If present must be less than total length of stay |

| | | | | | |
|---|---|---|---|---|---|
| 16 | Filler | X(61) | | 190 250 | |

♦ Accommodations may occur up to 5 times.
+ Accommodations 1 - 5 are required as applicable.
++ Accommodations 2 - 5 require the same format as Accommodation 1.

(5)

Record Name = Ancillary Services
Record Type = 40
Record No. = 5

| Field No. | Field Name | Pic-ture | Spec. | Field Position From-Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '40' | XX | L/B | 1 2 | - Must be first record following last occurrence of IP Accommodations Record Type '30' or following previous Record Type '40' |
| *2 | Sequence | 99 | R/Z | 3 4 | - Must be numeric<br>- If first record following IP Accommodations Record Type '30' sequence must = '01'<br>- For each subsequent occurrence of Record Type '40' sequence must be incremented by one |
| *3 | Medical Record Number | X(10) | L/B | 5 14 | - Must be present<br>- Must equal Medical Record Number from Discharge Record Type '20' |
| 4 | Filler | X(7) | | 15 21 | |
| | ANCILLARIES 1♦ | X(33) | | 22 54 | |
| *5 | Revenue Code (Ancillary) | X(3) | L/B | 22 24 | - If present must be valid code as specified in 114.1 CMR 17.06(2)(c)+ |
| 6 | Filler | X(5) | | 25 29 | |
| *7 | Units of Service (Ancillary) | X(5) | R/Z | 30 34 | - Must be present if related Revenue Code is present<br>- Must be present if Revenue Code 762 or 769 are present |
| 8 | Filler | X | | 35 35 | |
| *9 | Total Charges (Service) | 9(6) | R/Z | 36 41 | - Must be present if related Revenue Code is present<br>- Must exceed one dollar<br>- Accumulate Total Charges (Service) for balancing against Total Charges (Ancillaries) in Patient Control Record Type '90' |
| 10 | Filler | X(13) | | 42 54 | |
| *11 | Ancillaries 2++ | X(33) | | 55 87 | - May only be present if Ancillaries 1 present+<br>- Same as Ancillaries 1 |
| *12 | Ancillaries 3++ | X(33) | | 88 120 | - May only be present if Ancillaries 2 present+<br>- Same as Ancillaries 1 |
| *13 | Ancillaries 4++ | X(33) | | 121 153 | - May only be present if Ancillaries 3 is present+ |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | - Same as Ancillaries 1 |
| *14 | Ancillaries 5[++] | X(33) | | 154 186 | - May only be present if Ancillaries 4 present[+]<br>- Same as Ancillaries 1 |
| *15 | Leave of Absence Days | 9(3) | | 187 189 | |
| 16 | Filler | X(61) | | 190 250 | |

♦ Ancillaries may occur up to 5 times.
[+] Ancillaries 1 - 5 are required as applicable.
[++] Ancillaries 2 - 5 require the same format as Ancillaries 1.

(6)

Record Name = Medical - Diagnosis
Record Type = 50
Record No. = 6

| Field No. | Field Name | Pic-ture | Spec. | Field Position From-Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type ‘50' | XX | L/B | 1 2 | - Must be first record following last occurrence of Ancillary Services Record Type '40' |
| *2 | Medical Record Number | X(10) | L/B | 3 12 | - Must be present<br>- Must equal Medical Record Number from Discharge Record Type '20' |
| *3 | Principal External Cause of Injury Code | X(6) | L/B | 13 18 | - Must be present if principal diagnosis is ICD-9-CM codes 800-904.9 or 910-995.89<br>- May be present if Principal Diagnosis is ICD-9-CM codes 996-999.9<br>- If present, must be a valid ICD-9-CM E-code (E800-E999) excluding E849.0 - E849.9<br>- Principal E-code shall be recorded in designated field and not be present in Diagnoses Codes 1-9<br>- Associated E-codes, present in the Associated Diagnosis field, shall only be permitted when a Principal E-Code is entered. |
| 4 | Filler | X(1) | | 19 19 | |
| *5 | Principal Diagnosis Code | X(5) | L/B | 20 24 | - Must be present<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 6 | Filler | X(2) | | 25 26 | |
| *7 | Assoc. Diagnosis Code I | X(5) | L/B | 27 31 | - Only permitted if a principal diagnosis is entered |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | - Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 8 | Filler | X(2) | | 32 33 | |
| *9 | Assoc. Diagnosis Code II | X(5) | L/B | 34 38 | - May only be entered if Assoc. Diagnosis Code I is entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 10 | Filler | X(2) | | 39 40 | |
| *11 | Assoc. Diagnosis Code III | X(5) | L/B | 41 45 | - May only be entered if Assoc. Diagnosis Code II is entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 12 | Filler | X(2) | | 46 47 | |
| *13 | Assoc. Diagnosis Code IV | X(5) | L/B | 48 52 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 14 | Filler | X(2) | | 53 54 | |
| *15 | Assoc. Diagnosis Code V | X(5) | L/B | 55 59 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 16 | Filler | X(2) | | 60 61 | |
| *17 | Assoc. Diagnosis Code VI | X(5) | L/B | 62 66 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 18 | Filler | X(2) | | 67 68 | |
| *19 | Assoc. Diagnosis Code VII | X(5) | L/B | 69 73 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 20 | Filler | X(2) | | 74 75 | |

| | | | | | |
|---|---|---|---|---|---|
| *21 | Assoc. Diagnosis Code VIII | X(5) | L/B | 76 80 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 22 | Filler | X(2) | | 81 82 | |
| *23 | Assoc. Diagnosis Code IX | X(5) | L/B | 83 87 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 24 | Filler | X(2) | | 88 89 | |
| *25 | Assoc. Diagnosis Code X | X(5) | L/B | 90 94 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 26 | Filler | X(2) | | 95 96 | |
| *27 | Assoc. Diagnosis Code XI | X(5) | L/B | 97 101 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 28 | Filler | X(2) | | 102 103 | |
| *29 | Assoc. Diagnosis Code XII | X(5) | L/B | 104 108 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 30 | Filler | X(2) | | 109 110 | |
| *31 | Assoc. Diagnosis Code XIII | X(5) | L/B | 111 115 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific diagnosis |
| 32 | Filler | X(2) | | 116 117 | |
| *33 | Assoc. Diagnosis Code XIV | X(5) | L/B | 118 122 | - May only be entered if the previous diagnosis fields are entered<br>- Must be valid ICD-9-CM code in diagnosis file<br>- Sex of patient must agree with diagnosis code for sex specific |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | diagnosis |
| 34 | Filler | X(2) | | 123 124 | |
| *35 | Attending Physician License Number (Board of Registration in Medicine Number) | X(6) | L/B | 125 130 | - Must be present<br>- Must be a valid and current Mass. Board of Registration in Medicine license number, or<br>- Must be “DENSG”, “PODTR”, “Other” or “MIDWIF” as specified in 17.05 (6)(d). |
| 36. | Filler | X(2) | | 131 132 | |
| *37. | Operating Physician License Number (Board of Registration in Medicine Number) | X(6) | L/B | 133 138 | - If present, must be a valid and current Mass. Board of Registration in Medicine license number or<br>- If present, must be “DENSG”, “PODTR” , “Other” or “MIDWIF” as specified in 17.05 (6)(e). |
| 38. | Filler | X(2) | | 139 140 | |
| *39. | Number of ANDs | 9(4) | | 141 144 | - Must not exceed total accommodation days |
| 40. | Filler | X(3) | | 145 147 | |
| *41. | Other Caregiver | X | | 148 148 | - May be present<br>- If present must be a valid code as specified in 114.1 CMR 17.06 (3) |
| *42. | Attending Physician National Provider Identifier (NPI) | X(8) | | 149 156 | - May be present when available |
| *43. | Attending Physician National Provider Identifier (NPI) Location Code | X(2) | | 157 158 | - May be present when available |
| *44. | Operating Physician National Provider Identifier (NPI) | X(8) | | 159 166 | - May be present when available |
| *45. | Operating Physician National Provider Identifier (NPI) Location Code | X(2) | | 167 168 | - May be present when available |
| *46. | Additional Caregiver National Provider Identifier (NPI) | X(8) | | 169 176 | - May be present when available |
| *47. | Additional Caregiver NPI Location Code | X(2) | | 177 178 | - May be present when available |
| 48. | Filler | X(72) | | 179 250 | |

(7)

Record Name = Medical - Procedure
Record Type = 60
Record No. = 7

| Field No. | Field Name | Pic-ture | Spec. | Field Position From-Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type ‘60' | XX | L/B | 1 2 | - Must be first record following Medical - Diagnosis Record Type '50' |
| *2 | Medical Record Number | X(10) | L/B | 3 12 | - Must be present<br>- Must equal Medical Record Number from Discharge Record Type '20' |
| *3. | Principal Procedure Code | X(5) | L/B | 13 17 | - If entered must be valid ICD-9-CM code<br>- Must be valid for patient sex based on table |
| 4. | Filler | X(4) | | 18 21 | |
| *5. | Date of Principal Procedure (CCYYMMDD) | X(8) | L/B | 22 29 | - Must be present if Principal Procedure code is present<br>- Must be valid date<br>- Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in 114.1 CMR 17.06(1)(e)<br>- Must not be later than discharge date |
| *6. | Significant Procedure I | X(5) | L/B | 30 34 | - May only be present if Principal Procedure Code is present<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 7. | Filler | X(4) | | 35 38 | |
| *8. | Significant Proc. I Date (CCYYMMDD) | X(8) | L/B | 39 46 | - Must be present if Significant Procedure Code is present<br>- Must be valid date<br>- Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory Surgery or Observation as specified in 114.1 CMR 17.06(1)(e)<br>- Must not be later than discharge date |
| *9. | Significant Proc. II | X(5) | L/B | 47 51 | - May only be present if Significant Procedure I present<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 10. | Filler | X(4) | | 52 55 | |
| *11. | Significant Proc. II Date (CCYYMMDD) | X(8) | L/B | 56 63 | - Must be present if Significant Procedure II code is present<br>- Must be valid date<br>- Must not be earlier than 3 days prior to date of admission unless Admission Source is Ambulatory |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Surgery or Observation as specified in 114.1 CMR 17.06(1)(e)<br>- Must not be later than discharge date |
| *12. | Significant Proc. III | X(5) | L/B | 64 68 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 13. | Filler | X(4) | | 69 72 | |
| *14. | Significant Proc. IV | X(5) | L/B | 73 77 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 15. | Filler | X(4) | | 78 81 | |
| *16. | Significant Proc. V | X(5) | L/B | 82 86 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 17. | Filler | X(4) | | 87 90 | |
| *18. | Significant Proc. VI | X(5) | L/B | 91 95 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 19. | Filler | X(4) | | 96 99 | |
| *20. | Significant Proc. VII | X(5) | L/B | 100 104 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 21. | Filler | X(4) | | 105 108 | |
| *22. | Significant Proc. VIII | X(5) | L/B | 109 113 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 23. | Filler | X(4) | | 114 117 | |
| *24. | Significant Proc. IX | X(5) | L/B | 118 122 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 25. | Filler | X(4) | | 123 126 | |
| *26. | Significant Proc. X | X(5) | L/B | 127 131 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 27. | Filler | X(4) | | 132 135 | |
| *28. | Significant Proc. XI | X(5) | L/B | 136 140 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 29. | Filler | X(4) | | 141 144 | |
| *30. | Significant Proc. XII | X(5) | L/B | 145 149 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |

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|---|---|---|---|---|---|
| 31. | Filler | X(4) | | 150 153 | |
| *32. | Significant Proc. XIII | X(5) | L/B | 154 158 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 33. | Filler | X(4) | | 159 162 | |
| *34. | Significant Proc. XIV | X(5) | L/B | 163 167 | - May only be present if all previous procedure fields are entered<br>- Must be valid ICD-9-CM code<br>- Must be valid for patient sex |
| 35. | Filler | X(83) | | 168 250 | |

(8)

Record Name = Patient Control
Record Type = 90
Record No. = 8

| Field No. | Field Name | Pic-ture | Spec. | Field Position From-Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '90' | XX | L/B | 1 2 | - Must be first record following Medical - Procedure Record Type '60' |
| 2 | Filler | XX | | 3 4 | |
| *3 | Medical Record Number | X(10) | L/B | 5 14 | - Must be present<br>- Must equal Medical Record Number from Patient Record Type '20' |
| 4 | Filler | X(7) | | 15 21 | |
| *5 | Physical Record Count | 9(3) | R/Z | 22 24 | - Must equal total number of all Records Type '20', '30', '40', and '50' |
| *6 | Record Type 2x Count | 99 | R/Z | 25 26 | - Must equal number of Record Type'20' records<br>- Must = '01' |
| *7 | Record Type 3x Count | 99 | R/Z | 27 28 | - Must equal number of Record Type'30' records |
| *8 | Record Type 4x Count | 99 | R/Z | 29 30 | - Must equal number of Record Type'40' records |
| *9 | Record Type 5x Count | 99 | R/Z | 31 32 | - Must equal number of Record Type'50' records<br>- Must = '01' |
| *10 | Record Type 6x Count | 99 | R/Z | 33 34 | - Must equal number of Record Type'60' records<br>- Must = '01' |
| 11 | Filler | X(10) | | 35 44 | |
| *12 | Total Charges Spec. Services | 9(8) | R/Z | 45 52 | - Must be numeric |
| *13 | Total Charges Routine Services | 9(8) | R/Z | 53 60 | - Must be numeric |

| | | | | | |
|---|---|---|---|---|---|
| 14 | Filler | X(8) | | 61 68 | |
| *15 | Total Charges Ancillaries | 9(8) | R/Z | 69 76 | - Must equal sum of Total Charges (Services) from Ancillary Services Record Type '40' records |
| 16 | Filler | X(8) | | 77 84 | |
| *17 | Total Charges (All Chgs) | 9(10) | R/Z | 85 94 | - Must equal sum of Total Charges Special Services, Total Charges Routine Services, and Total Charges Ancillaries from Patient Control Record Type '90' record<br>- Must equal sum of Total Charges Accommodations from IP Accommodations Record Type '30' records and Total Charges (Services) from Ancillary Services Record Type '40' records |
| 18 | Filler | X(156) | | 95 250 | |

(9)

Record Name = Provider Batch Control
Record Type = 95
Record No. = 9

| Field No. | Field Name | Pic-ture | Spec. | Field Position From-Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '95' | XX | L/B | 1 2 | - Must follow Patient Control Record Type '90' |
| *2 | MDPH Hosp. Computer No. | 9(4) | R/Z | 3 6 | - Must equal Provider Record Type '10' |
| 3 | Filler | X(4) | | 7 10 | |
| *4 | Type of Batch | XX | L/B | 11 12 | - Must be present and must be valid code as specified in 114.1 CMR 17.06(4) |
| *5 | Number of Discharges | 9(5) | R/Z | 13 17 | - Must equal number of Patient Control Record Type '90'records |
| *6 | Total Days | 9(5) | R/Z | 18 22 | - Must equal total accommodation days from all Record Type '30' Records |
| *7 | Total Charges Accommodations | 9(10) | R/Z | 23 32 | - Must equal sum of Total Charges Spec. Services and Total Charges Routine Services. from Patient Control Record Type '90' records |
| 8 | Filler | X(8) | | 33 40 | |
| *9 | Total Charges Ancillaries | 9(10) | R/Z | 41 50 | - Must equal sum of Total Charges Ancillaries from Patient Control Record Type '90' records |
| 10 | Filler | X(200) | | 51 250 | |

(10)

Record Name = Tape Control
Record Type = 99
Record No. =10

| Field No. | Field Name | Picture | Spec. | Field Position From - Through | Edit Specifications |
|---|---|---|---|---|---|
| *1 | Record Type '99' | XX | L/B | 1 2 | - Must follow Provider Batch Control Record Type '95' |
| *2 | Submitter EIN | 9(10) | L/B | 3 12 | - Must equal Submitter EIN from Label Record Type '01' record |
| 3 | Filler | X(8) | | 13 20 | |
| *4 | No. of Providers on Tape | 9(3) | R/Z | 21 23 | - Must equal number of Provider Record Type '10' records |
| 5 | Filler | X(5) | | 24 28 | |
| *6 | Count of Batches | 9(4) | R/Z | 29 32 | - Must equal number of Provider Batch Control Record Type '95' records |
| *7 | Batch Type "11" Count | 9(4) | R/Z | 33 36 | - Must equal total number of Record Type '95' records where Batch Type = 11 |
| *8 | Batch Type "22" Count | 9(4) | R/Z | 37 40 | - Must equal total number of Record Type '95' records where Batch Type = 22 |
| *9 | Batch Type "33" Count | 9(4) | R/Z | 41 44 | - Must equal total number of Record Type '95' records where Batch Type = 33 |
| *10 | Batch Type "99" Count | 9(4) | R/Z | 45 48 | - Must equal total number of Record Type '95' records where Batch Type = 99 |
| 11 | Filler | X(202) | | 49 250 | |

*** MUST PROVIDE THOSE DATA ELEMENTS WHICH ARE ASTERISKED (*)**

## 17.05: Inpatient Data Element Definitions

114.1 CMR 17.05 defines each specific data element except where definitions appear unambiguous. Definitions are presented in the sequential order that the data elements appear in the record types in 114.1 CMR 17.04. (e.g., Data elements from record type '01' requiring definition are presented first; those from record type '10' follow.) The code tables for all data elements which require code value descriptions are defined in 114.1 CMR 17.06. *Definitions are presented only for asterisked data elements which are the data elements required by the Division of Health Care Finance and Policy*.

**(1) Record Type '01'**

**(a) Submitter Name**. The name of the organization submitting the tape which may be an individual hospital or a processor submitting data for one or more hospitals.

**(b) Receiver Identification**. A control field for insuring the correct tape is being forwarded to the Division. Code this field `HCF'. ('HCF' is preferred but 'MRSC' will still be accepted)

**(c) Processing Date**. The date the tape is created.

**(d) Reel Number**. The sequential number of the tape used as a control when more than one tape is being provided by the submitter. If only one tape is submitted the reel number is '01'. Each additional tape is sequentially numbered.

**(2) Record Type '10'**

**(a) Type of Batch**. A code indicating the type of data submission. See codes in 114.1 CMR 17.06 (4).

**(b) Batch Number**. The sequential numbering of hospital batches included on the tape submission and used to identify multiple hospital batches on the same tape. Each individual hospital's data is provided in a batch. Thus, if only one hospital's data is on the tape the batch number is '1'. Each additional hospital's data is sequentially numbered, e.g. '2' or '3'.

**(c) MDPH Hospital Computer Number**. The Massachusetts Department of Public Health four digit number. See Attachment I.

**(d) Period Starting/Ending Dates**. These dates should coincide with the first day and last day of the quarter for which data is being submitted.

**(3) Record Type '20'**

**(a) Medical record number**. The unique number assigned to each patient within the hospital that distinguishes the patient and the patient's hospital record(s) from all others in that institution.

**(b) Patient Birth Date**. The date of birth of the patient. Record two digits for century, two digits for year, two digits for month, and two digits for day. When exact month and day are unknown, record 9's. If exact century and year are unknown, estimate.

**(c) Patient Employer's Zip Code**. The U.S. Post Office (nine digit) zip code which designates the patient's employer's zip code. Until the nine digit zip code is widely used, left justify the relevant five digit code and blank fill the remaining four digits. When a patient is covered under someone else's policy, e.g., that of the patient's spouse or parent, record the U.S. Post Office (nine digit) zip code for the employer of the spouse or parent, i.e. the employer of the policy holder. If a patient is unemployed and not covered under someone else's policy, record 0's.

**(d) Type of Admission**. A code indicating the priority status of the admission.

**(e) Source of Admission**. A code indicating the source referring or transferring this patient to inpatient status in the hospital. The Primary Source of Admission should be the originating referring or transferring facility or primary referral source causing the patient to enter the hospital's care. The Secondary Source of Admission should be the secondary referring or transferring source for the patient. If the patient has been transferred from a SNF to the hospital's Clinic and is then admitted, report the Primary Source of Admission as "5 - Transfer from SNF" and report the Secondary Source of Admission as "Within Hospital Clinic Referral". If the patient has been seen in Observation or the hospital's ER as well as has more than 2

other Admission Sources and is then admitted, use Revenue Code 762 or 450 to report charges for Observation Room or ER, respectively, and use the alternate outpatient department or transferring or referring sources for the Primary and Secondary Source of Admission. For example, if the patient is seen in the hospital's ER without contacting his physician or health plan and is then transferred to Observation before being admitted, the Primary Source of Admission should be "M - Walk-In/Self Referral, the Secondary Source of Admission should be "R - Within Hospital Emergency Room Transfer" and charges should be reported in ancillary revenue code 762 for Observation Room.

The method for determining the Primary Source of Admission to report for each discharge should be based on the following Source of Admission hierarchy:

| Primary Source of Admission Hierarchy | | | Source of Admission Codes* | |
|---|---|---|---|---|
| 1. | Transferred from another facility | Yes | 4, 5, or 6 | If no, refer to #2. |
| 2. | Referred or transferred from Outside Hospital Clinic or Outside Ambulatory Surgery | Yes | L, or T | If no, refer to #3. |
| 3. | Transferred from Outside Hospital Emergency Room | Yes | 7 | If no, refer to #4 |
| 4. | Referred or transferred from Court/Law Enforcement | Yes | 8 | If no, refer to #5 |
| 5. | Direct Physician Referral, Direct Health Plan/HMO Referral or Walk-In/Self Referral | Yes | 1, 3, or M | If no, refer to #6 |
| 6. | Extramural Birth | Yes | W | If no, refer to #7 |
| 7. | Transferred from Within Hospital Emergency Room (should only be used for secondary Source of Admission unless the hospital is unable to determine the originating or Primary Source of Admission) | Yes | R | If no, refer to #8 |
| 8. | Referred or transferred from Within Hospital Clinic or Ambulatory Surgery | Yes | 2 or Y | If no, refer to #9. |
| 9. | Observation Referral | Yes | X | If no, refer to #10 |
| 10. | Other or information not available | Yes | 9 or 0 | |

*** Note: Refer to 17.06 (1)(e) for detailed listing of Source of Admission codes and definitions**

**(f) Extramural Birth**. The birth of a newborn in a non-sterile environment; birth outside of the hospital.

**(g) Observation.** If the Observation Source of Admission (code 'X') is reported, related observation room charges must also be reported for the Observation Ancillary Revenue Code 762. However, if the patient has been seen in Observation as well as another outpatient department and is then admitted, use Revenue Code 762 to report observation room charges and use the alternate outpatient department as the Source of Admission.

**(h) Normal Newborn**. A healthy infant born at 37 weeks gestation or later.

**(i) Premature Newborn**. An infant born after less than 37 weeks of gestation.

**(j) Sick Newborn**. A newborn suffering from disease or from a severe condition which requires treatment.

**(k) Patient Zip Code**. The U.S. Post Office (nine digit) zip code which designates the patient's residence. Until the nine digit zip code is widely used, left justify the relevant five digit zip code, and blank fill the remaining four digits. If the patient's residence is outside of the United States, record 7's. If unknown record 0's.

**(l) Admission Date**. The date the patient was admitted to the hospital as an inpatient for this episode of care.

**(m) Discharge Date**. The date the patient was discharged from inpatient status in the hospital for this episode of care.

**(n) Patient Status**. A code indicating the patient's status upon discharge and/or the destination to which the patient was referred or transferred upon discharge.

**(o) Intermediate Care Facility (ICF).** An ICF is a facility that provides routine services or periodic availability of skilled nursing, restorative and other therapeutic services, in addition to the minimum basic care and services required for patients whose condition is stabilized to the point that they need only supportive nursing care, supervision and observation. A facility is an ICF if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR, 150.001(B)(3): Supportive Nursing Care Facilities (Level III).

**(p) Rest Home**. A Rest Home is a facility that provides or arranges to provide a supervised supportive and protective living environment and support services incident to old age for residents having difficulty in caring for themselves. This facility's services and programs seek to foster personal well-being, independence, an optimal level of psychosocial functioning, and integration of residents into community living. A facility is a Rest Home if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR 150.001(B)(4): Resident Care Facilities (Level IV).

**(q) Skilled Nursing Facility (SNF).** A SNF is a facility that provides continuous skilled nursing care and meaningful availability of restorative services and other therapeutic services in addition to the minimum basic care and services required for patients who show potential for improvement or restoration to a stabilized condition or who have a deteriorating condition requiring skilled care. A facility is a SNF if it meets the definition in the Department of Public Health's Licensing Regulation of Long Term Care Facilities, 105 CMR, 150.001(B)(2): Skilled Nursing Care Facilities (Level II). Use Routine Accommodation Revenue Code 198 for SNF.

**(r) Billing number**. The unique number assigned to each patient's bill that distinguishes the patient and their bill from all others in that institution. Newborns must have their own billing number separate from that of their mother.

**(s) Claim Certificate Number**. This number is also referred to as the Medicaid Recipient Identification Number. If the Payer type Code is equal to "4" (Medicaid) or "B" (Medicaid Managed Care) as specified in 114.1 CMR 17.06(1)(g), the Medicaid Recipient Identification Number must be recorded. This number is the patient's Social Security Number and one additional random number (ten characters).

**(t) Veteran Status**. A code indicating the patient's status as an United States veteran.

**(u) Patient Social Security Number**. The patient's social security number is to be reported as a nine digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record", by reporting the social security number as "000000001". The number to be reported for the patient's

social security number is the patient's social security number, not the social security number of some other person, such as the husband or wife of the patient. The social security number for the mother of a newborn should not be reported in this field; The field Mother's Social Security Number is a separate field designated for the social security of the newborn's mother as specified in 17.05 (3)(y). The patient's social security number will be encrypted into a Unique Health Information Number (UHIN) and the social security number will never be considered a case mix data element. Only the UHIN will be considered a data base element and only this encrypted number will be used by the Division.

**(v) Birth Weight of Newborn**. The specific birth weight of the newborn recorded in grams.

**(w) Do Not Resuscitate (DNR) Status.** A status indicating that the patient had a physician order not to resuscitate or the patient had a status of receiving palliative care only. Do not resuscitate status means not to revive from potential or apparent death or that a patient was being treated with comfort measures only.

**(x) Mother's Social Security Number.** The social security number of the patient's mother is to be reported for newborns or for infants less than one year old as a nine digit number. If the mother's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record", by reporting the social security number as "000000001". The mother's social security number will be encrypted into a Unique Health Information Number (UHIN) and the social security number will never be considered a case mix data element. Only the UHIN will be considered a data base element and only this encrypted number will be used by the Division.

**(y) Mother' s Medical Record Number.** The medical record number assigned within the hospital to the newborn's mother is to be reported for the newborn. The medical record number of the newborn's mother distinguishes the patient's mother and the patient's mother's hospital record(s) from all others in that institution.

**(z) Facility Site Number**. A hospital determined number used to distinguish multiple sites that fall under one Massachusett's Department of Public Health (MDPH) facility number.

**(4) Record Type '30'**

**(a) Sequence**. A code to identify multiple occurrences of Record Type '30' when a single reporting of this record is not sufficient to capture all of the routine and special care accommodations used by this discharged patient. This code is a sequential recording of the number of occurrences of this record, e.g. '01' or '02'.

**(b) Revenue Code**. A numeric code which identifies a particular routine or special care accommodation. The revenue codes are taken from the UB-92 revenue codes and correspond to specific cost centers in the DHCFP-403 cost report and HURM. Exceptions include Chronic Care and Subacute which have DHCFP assigned revenue codes versus UB-92 assigned revenue codes.

***Rehabilitation Routine Accommodation.*** A patient's routine accommodation should be reported as 'Rehabilitation' if the patient's care requires comprehensive therapy and services necessary to improve the functional limitations resulting from the recent onset, regression or progression of an illness or disease and to obtain optimal health. Rehabilitative programs are usually well coordinated, integrated, goal oriented, evaluative and/or therapeutic and utilize an interdisciplinary approach with services such as intensive skilled rehabilitation nursing, physician therapy, occupational therapy, speech therapy, social services, prosthetic and /or orthotic fitting, psychological services, recreation therapy, dental services, special education, vocational assessment and

counseling. Use Routine Accommodation Revenue Code 118 for Rehabilitation.

***Chronic Care Routine Accommodation.*** A patient's routine accommodation should be reported as 'Chronic Care' if the patient's care and treatment require frequent or daily physician visits in addition to skilled nursing and regular intervention by other therapists and technicians with an average length of stay greater than 25 days; the illness is marked by long duration, frequent occurrence and is expected to continue for an extended period. Types of chronic care services may include patients requiring 24 hour per day parenteral pain management, general palliative care, aggressive interventions for stage III and IV decubiti, hyperalimentation, long term antibiotic administration and peritoneal dialysis. Examples of chronic disease include long term endocarditis, long term osteomyelitis, chronic degenerative disease of the central nervous system, such as Alzheimer's disease, end stage chronic organ failure, end stage AIDS and end stage cancer. Use Routine Accommodation Revenue Code 192 for Chronic Care.

***Subacute Care Routine Accommodation.*** A patient's routine accommodation should be reported as 'Subacute Care" if the patient requires short term comprehensive care and specialized resources, such as interdisciplinary teams, case managers, highly trained physicians and nurses, and specialized protocols such as critical pathways and measured outcomes, before discharge home. Subacute care can be provided in a variety of settings, such as skilled nursing facilities (either freestanding or hospital based) or transitional care units. Use Routine Accommodation Revenue Code 196 for Subacute Care.

***Transitional Care Unit Routine Accommodation (TCU).*** A patient's routine accommodation should be reported as TCU if the patient is admitted to this type of unit. TCU is a type of subacute unit. Use Routine Accommodation Revenue Code 197 for Transitional Care.

**(c) Leave of Absence**. The count in days of a patient's absence with physician approval during a hospital stay without formal discharge and readmission to the facility.

**(d) Units of Service**. A quantitative measure of utilization of specific hospital services corresponding to prescribed revenue codes. For routine and special care accommodations the units of service are "days".

**(e) Total Charges (Accommodation)**. The full, undiscounted charges summarized by specific accommodation revenue code(s). Total charges should not include charges for telephone service, television or private duty nurses. Any charges for a leave of absence period are to be included in the routine accommodation charges for the appropriate service (medical/surgical, psychiatry) from which the patient took the leave of absence. Any other routine admission charges or daily charges under which expenses are allocated to the routine or special care reporting centers on the DHCFP-403 must be included in the total charges.

**(5) Record Type '40'**

**(a) Sequence**. A code to identify multiple occurrences of Record Type '40' when a single reporting of this record is not sufficient to capture all of the ancillary services used by this discharge patient. This code is a sequential recording of the number of occurrences of this record, e.g. '01' or '02'.

**(b) Revenue Code**. A numeric code which identifies a particular ancillary service. The revenue codes are taken from the UB-92 revenue codes and correspond to specific cost centers in the DHCFP-403 cost report and HURM.

**1. Revenue Center 760 - General Observation/Treatment Room**. This ancillary revenue center is designated for any other charges associated with "observation" or "Treatment Room" that are not captured in revenue centers 761, 762, or 769.

**2. Revenue Center 762 - Observation Room.** This ancillary revenue center is designated for Observation Room charges only. Charges should be reported under revenue center code 762 for any patient that uses an Observation Room and is admitted. If the patient is not admitted, refer to section 17.08: *Outpatient Observation Data Specifications.*

**3. Revenue Center 769 - Other Treatment/Observation Room.** This ancillary revenue center is designated for other atypical inpatient Observation Room charges only. An example of atypical inpatient Observation Room charges might be room charges for a patient held for observation purposes before being discharged that is not categorized as "observation status" or not placed in an observation bed.

**(c) Units of Service**. For the majority of ancillary services, the units of service are not specified and zeros should be used to fill the blanks. The Unit of Service for Ancillary Services is required for Revenue Center 762 - Observation Room and 769 - Other Observation Room. The required unit of service for Observation Room is hours. For hospitals that collect this information in a range, report the information using the end point and round up to the highest whole number. For example, if the range is 0 - 4 hours, then '4' should be reported. Hospitals that collect this unit as days will need to convert it to an hour equivalent. For example, 1 day should be reported as '24' (for 24 hours).

**(d) Total Charges (Ancillary Services).** The full, undiscounted charges summarized by a specific ancillary service revenue code(s).

**(6) Record Type '50'**

**(a) External Cause of Injury Code (E-Code).** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes E800-E999 (E-codes) are used to categorize events and conditions describing the external cause of injuries, poisonings, and adverse effects. E-codes adequate to describe the external cause shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999) or where certain other conditions from Chapters 1 through 16 of the ICD-9-CM (001 - 799) demonstrate that an additional E-code is appropriate. The principal E-code shall describe the mechanism that caused the most severe injury, poisoning, or adverse effect. Additional E-codes used to report place of occurrence or to completely describe the mechanism(s) that contributed to the injury or poisoning or the causal circumstances surrounding any injury or poisoning should be reported in the Associated Diagnosis Code section.

**(b) Principal Diagnosis Code**. The ICD-9-CM diagnosis code corresponding to the condition established after study to be chiefly responsible for the admission of the patient for hospital care.

**(c) Associated Diagnosis Code**. The ICD-9-CM diagnosis code corresponding to conditions that co-exist with the principal diagnosis at the time of admission, or develop subsequently, which affect the treatment received or the length of the patient's hospital stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

**(d) Attending Physician License Number**. The Massachusetts Board of Registration in Medicine license number of the clinician of record at discharge who is responsible for the discharge summary, who is primarily and largely responsible for the care of the patient from the

beginning of the hospital episode. The attending physician license number will be encrypted into a unique physician number (UPN) at the Division. If the attending physician does not have a license number from the Massachusetts Board of Registration in Medicine, use the following codes in the indicated circumstances:

| | |
|---|---|
| DENSG | for each Dental Surgeon. |
| PODTR | for each Podiatrist. |
| OTHER or if | for other situations where no permanent license number is assigned a limited license number is assigned. |
| MIDWIF | for each midwife. |

**(e) Operating Physician License Number**. The Massachusetts Board of Registration in Medicine license number for the clinician who performed the principal procedure. The operating physician license number will be encrypted into a unique physician number (UPN) at the Division. If the operating physician does not have a license number from the Massachusetts Board of Registration in Medicine, use the following codes in the indicated circumstances:

| | |
|---|---|
| DENSG | for each Dental Surgeon. |
| PODTR | for each Podiatrist. |
| OTHER or if | for other situations where no permanent license number is assigned a limited license number is assigned. |
| MIDWIF | for each midwife. |

**(f) Number of Administratively Necessary Days**. The number of days which were deemed clinically unnecessary in accordance with review by the Division of Medical Assistance.

**(g) Other Caregiver**. The primary caregiver responsible for the patient's care other than the Attending Physician, Operating Room Physician or Nurse Midwife as specified in 114.1 CMR 17.06 (3)

**(7) Record Type '60'**

**(a) Principal Procedure Code**. The ICD-9-CM procedure code that is usually the procedure most related to the principal diagnosis and performed for definitive treatment of the principal diagnosis rather than for diagnostic or exploratory purposes, or necessary to treat a complication of the principal diagnosis.

**(b) Date of Principal Procedure**. The century, year, month, and day on which this procedure was performed.

**(c) Significant Procedure Code**. The ICD-9-CM procedure code usually corresponding to additional procedures which carry an operative or anesthetic risk or require highly trained personnel, special equipment or facilities.

**(8) Record Type '90'**

**(a) Physical Record Count**. The count of the total number of records provided for this particular patient discharge excluding Record Type '90'.

**(b) Record Type Count**. The count of the number of each type of separate records from record '20' through '50'. For instance. Record Type "3X" is the count of all record types '30'.

**(c) Total Charges Special Care Services**. The full, undiscounted charges for patient care summarized by prescribed revenue code for accommodation services in those special care units which provide patient care of a more intensive nature than that provided in the general medical care units, as specified in 114.1 CMR 17.06(2)(b).

**(d) Total Charges Routine Services**. The full, undiscounted charges for patient care summarized by prescribed revenue code for routine accommodation services as specified in 114.1 CMR 17.06(2)(a).

**(e) Total Charges Ancillaries**. The full, undiscounted charges for patient care summarized by prescribed revenue code for ancillary services as specified in 114.1 CMR 17.06(2)(c).

**(f) Total Charges (All Charges) .** The full, undiscounted charges for patient care summarized by prescribed revenue code for special care, routine accommodation, and ancillary services. Total charges should not include charges for telephone service, television or private duty nurses. Any charges for a leave of absence period are to be included in the routine accommodation charges for the appropriate service from which the patient took the leave of absence. Any other routine admission charges or daily charges under which expenses are allocated to the reporting centers on the DHCFP-403 must be included in total charges.

**(9) Record Type '95'**

**(a) Total Days**. The count of total patient days represented by discharges in this quarter net of any leave of absence days.

**(10) Record Type '99'**

**(a) Count of Batches**. The total number of batches included on this tape.

**(b) Batch Type Count**. The count of the number of each type of separate batch from "11" through "99". For example, batch type "11" is the count of all routine resubmissions.

## 17.06: Inpatient Data Code Tables

The following are the code tables for all data elements requiring codes not otherwise specified in 114.1 CMR 17.00. They are listed in order of record type.

**(1) Record Type '20'**

**(a)**

| * SEX CODE | * Patient Sex Definition |
|---|---|
| M | Male |
| F | Female |
| U | Unknown |

**(b)**

| * RACE CODE | * Patient Race Definition |
|---|---|
| 1 | White |
| 2 | Black |
| 3 | Asian |
| 4 | Hispanic |
| 5 | American Indian |
| 6 | Other |
| 9 | Unknown |

**(c)**

| *MARSTA CODE | * MARITAL STATUS DEFINITION |
|---|---|
| S | Never Married |
| M | Married |
| X | Legally Separated |
| D | Divorced |
| W | Widowed |

**(d)**

| * TYPADM CODE | * Type of Admission Definition |
|---|---|
| 1 | Emergency |
| 2 | Urgent |
| 3 | Elective |
| 4 | Newborn |
| 5 | Information Unavailable |

**(e)**

| * SRCADM CODE | * Source of Admission Definition |
|---|---|
| 0 | Information Not Available |
| 1 | Direct Physician Referral |
| 2 | Within Hospital Clinic Referral |
| 3 | Direct Health Plan Referral/HMO Referral |
| 4 | Transfer from an Acute Hospital |
| 5 | Transfer from a Skilled Nursing Facility |
| 6 | Transfer from Intermediate Care Facility |
| 7 | Outside Hospital Emergency Room Transfer |
| 8 | Court/Law Enforcement |
| 9 | Other (to include level 4 Nursing Facility) |
| L | Outside Hospital Clinic Referral |
| M | Walk-In/Self Referral |

| SRCADM CODE | FOR NEWBORN: |
|---|---|
| 0 | Information not Available |
| 1 | Normal Delivery |
| 2 | Premature Delivery |
| 3 | Sick Baby |
| 4 | Extramural Birth |

| | |
|---|---|
| R | Within Hospital Emergency Room Transfer |
| T | Transfer from Another Institution's Ambulatory Surgery |
| W | Extramural Birth |
| X | Observation |
| Y | Within Hospital Ambulatory Surgery Transfer |

**(f)**

| * PASTA CODE | * Patient Status Definition |
|---|---|
| 01 | Discharged/transferred to home or self care (routine discharge) |
| 02 | Discharged/transferred to another short-term general hospital |
| 03 | Discharged, transferred to Skilled Nursing Facility (SNF) |
| 04 | Discharged/transferred to an Intermediate Care Facility (ICF) |
| 05 | Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution |
| 06 | Discharged/transferred to home under care of organized home health service organization |
| 07 | Left against medical advice |
| 08 | Discharged/transferred to home under care of a Home IV Drug Therapy Provider |
| 09 | Not used |
| 10 | Discharged/transferred to chronic hospital |
| 11 | Discharged/transferred to mental health hospital |
| 12 | Discharge Other |
| 13 | Discharge/transfer to rehab hospital |
| 14 | Discharge/transfer to rest home |
| 15 | Discharge to Shelter |
| 20 | Expired (or did not recover - Christian Science Patient) |
| 50 | Discharged to Hospice - Home |
| 51 | Discharged to Hospice Medical Facility |

**(g) PAYER TYPE:**

| * PAYER TYPE CODE | PAYER TYPE ABBREVIATION | * PAYER TYPE DEFINITION |
|---|---|---|
| 1 | SP | Self Pay |
| 2 | WOR | Worker's Compensation |
| 3 | MCR | Medicare |
| F | MCR-MC | Medicare Managed Care |
| 4 | MCD | Medicaid |
| B | MCD-MC | Medicaid Managed Care |
| 5 | GOV | Other Government Payment |
| 6 | BCBS | Blue Cross |
| C | BCBS-MC | Blue Cross Managed Care |
| 7 | COM | Commercial Insurance |
| D | COM-MC | Commercial Managed Care |
| 8 | HMO | HMO |
| 9 | FC | Free Care |
| 0 | OTH | Other Non-Managed Care Plans |
| E | PPO | PPO and Other Managed Care Plans Not Elsewhere Classified |
| J | POS | Point-of-Service Plan |
| K | EPO | Exclusive Provider Organization |
| T | AI | Auto Insurance |
| N | None | None (Valid only for Secondary Payer) |

**(h) SOURCE OF PAYMENT**:

| *SRCPAY CODE | * SOURCE OF PAYMENT DEFINITIONS | MATCH-ING PAYER TYPE CODE | PAYER TYPE ABBREVIATION |
|---|---|---|---|
| 1 | Harvard Community Health Plan | 8 | HMO |
| 2 | Bay State - a product of HMO Blue | C | BCBS-MC |
| 3 | Network Blue (PPO) | C | BCBS-MC |
| 4 | Fallon Community Health Plan (includes Fallon Plus, Fallon Affliates, Fallon UMass) | 8 | HMO |
| 5 | Invalid (replaced by #9) | | |
| 6 | Invalid (replaced by #251) | | |
| 7 | Tufts Associated Health Plan | 8 | HMO |
| 8 | Pilgrim Health Care | 8 | HMO |
| 9 | United Health Plan of New England (Ocean State) | 8 | HMO |
| 10 | Pilgrim Advantage - PPO | E | PPO |
| 11 | Blue Care Elect | C | BCBS-MC |
| 12 | Invalid (replaced by #49) | | |
| 13 | Community Health Plan Options (New York) | J | POS |
| 14 | Health New England Advantage POS | J | POS |
| 15 | Invalid (replaced by #158) | | |
| 16 | Invalid (replaced by #172) | | |
| 17 | Prudential Healthcare POS | D | COM-MC |
| 18 | Prudential Healthcare PPO | D | COM-MC |

| | | | |
|---|---|---|---|
| 19 | Matthew Thornton | 8 | HMO |
| 20 | HCHP of New England (formerly RIGHA) | 8 | HMO |
| 21 | Commonwealth PPO | E | PPO |
| 22 | Aetna Open Choice PPO | D | COM-MC |
| 23 | Guardian Life Insurance Company PPO | D | COM-MC |
| 24 | Health New England, Inc | 8 | HMO |
| 25 | Pioneer Plan | 8 | HMO |
| 26 | Invalid (replaced by #75) | | |
| 27 | First Allmerica Financial Life Insurance PPO | D | COM-MC |
| 28 | Great West Life PPO | D | COM-MC |
| 29 | Invalid (replaced by #171 and 250) | | |
| 30 | CIGNA (Indemnity) | 7 | COM |
| 31 | One Health Plan HMO (Great West Life) | D | COM-MC |
| 32 | Invalid (replaced by #157 and 158) | | |
| 33 | Mutual of Omaha PPO | D | COM-MC |
| 34 | New York Life Care PPO | D | COM-MC |
| 35 | United Healthcare Insurance Company - HMO (New for 1997) | D | COM-MC |
| 36 | United Healthcare Insurance Company - PPO (New for 1997) | D | COM-MC |
| 37 | HCHP-Pilgrim HMO (integrated product) | 8 | HMO |
| 38 | Health New England Select (self-funded) | 8 | HMO |
| 39 | Pilgrim Direct | 8 | HMO |
| 40 | Kaiser Foundation | 8 | HMO |
| 41 | Invalid (replaced by #157) | | |
| 42 | ConnectiCare Of Massachusetts | 8 | HMO |
| 43 | MEDTAC | 8 | HMO |
| 44 | Community Health Plan | 8 | HMO |
| 45 | Health Source New Hampshire | 8 | HMO |
| 46 | Blue CHiP (BCBS Rhode Island) | 8 | HMO |
| 47 | Neighborhood Health Plan | 8 | HMO |
| 48 | US Healthcare | 8 | HMO |
| 49 | Healthsource CMHC Plus PPO | E | PPO |
| 50 | Blue Health Plan for Kids | 6 | BCBS |
| 51 | Aetna Life Insurance | 7 | COM |
| 52 | Boston Mutual Insurance | 7 | COM |
| 53 | Invalid (no replacement) | | |
| 54 | Continental Assurance Insurance | 7 | COM |
| 55 | Guardian Life Insurance | 7 | COM |
| 56 | Hartford L&A Insurance | 7 | COM |
| 57 | John Hancock Life Insurance | 7 | COM |
| 58 | Liberty Life Insurance | 7 | COM |
| 59 | Lincoln National Insurance | 7 | COM |
| 60 | Invalid (replaced by #97) | | |
| 61 | Invalid (replaced by #96) | | |
| 62 | Mutual of Omaha Insurance | 7 | COM |
| 63 | New England Mutual Insurance | 7 | COM |
| 64 | New York Life Care Indemnity (New York Life Insurance) | 7 | COM |
| 65 | Paul Revere Life Insurance | 7 | COM |
| 66 | Prudential Insurance | 7 | COM |

| | | | |
|---|---|---|---|
| 67 | First Allmerica Financial Life Insurance | 7 | COM |
| 68 | Invalid (replaced by #96) | | |
| 69 | Corporate Health Insurance Liberty Plan | 7 | COM |
| 70 | Union Labor Life Insurance | 7 | COM |
| 71 | ADMAR | E | PPO |
| 72 | Healthsource New Hampshire | 7 | COM |
| 73 | United Health and Life (subsidiary of United Health Plans of NE) | 7 | COM |
| 74 | United Healthcare Insurance Company | 7 | COM |
| 75 | Prudential Healthcare HMO | D | COM-MC |
| 76 | Invalid (replaced by #270) | | |
| 77 | Options for Healthcare PPO | E | PPO |
| 78 | Phoenix Preferred PPO | D | COM-MC |
| 79 | Pioneer Health Care PPO | E | PPO |
| 80 | Tufts Total Health Plan PPO | E | PPO |
| 81 | HMO Blue | C | BCBS-MC |
| 82 | John Hancock Preferred | D | COM-MC |
| 83 | US Healthcare Quality Network Choice- PPO | E | PPO |
| 84 | Private Healthcare Systems PPO | E | PPO |
| 85 | Liberty Mutual | 7 | COM |
| 86 | United Health & Life PPO (Subsidiary of United Health Plans of NE) | E | PPO |
| 87 | CIGNA PPO | D | COM-MC |
| 88 | Freedom Care | E | PPO |
| 89 | Great West/NE Care | 7 | COM |
| 90 | Healthsource Preferred (self-funded) | E | PPO |
| 91 | New England Benefits | 7 | COM |
| 92 | Invalid (replaced by # 84, 166, 184) | | |
| 93 | Psychological Health Plan | E | PPO |
| 94 | Time Insurance Co | 7 | COM |
| 95 | Pilgrim Select - PPO | E | PPO |
| 96 | Metrahealth (United Health Care of NE) | 7 | COM |
| 97 | UniCare | 7 | COM |
| 98 | Healthy Start | 9 | FC |
| 99 | Other POS (not listed elsewhere) *** | J | POS |
| 100 | Transport Life Insurance | 7 | COM |
| 101 | Quarto Claims | 7 | COM |
| 102 | Wausau Insurance Company | 7 | COM |
| 103 | Medicaid (includes MassHealth) | 4 | MCD |
| 104 | Medicaid Managed Care-Primary Care Clinician (PCC) | B | MCD-MC |
| 105 | Invalid (replaced by #111) | | |
| 106 | Medicaid Managed Care-Central Mass Health Care | B | MCD-MC |
| 107 | Medicaid Managed Care - Community Health Plan | B | MCD-MC |
| 108 | Medicaid Managed Care - Fallon Community Health Plan | B | MCD-MC |
| 109 | Medicaid Managed Care - Harvard Community Health Plan | B | MCD-MC |
| 110 | Medicaid Managed Care - Health New England | B | MCD-MC |
| 111 | Medicaid Managed Care - HMO Blue | B | MCD-MC |
| 112 | Medicaid Managed Care - Kaiser Foundation Plan | B | MCD-MC |
| 113 | Medicaid Managed Care - Neighborhood Health Plan | B | MCD-MC |

| | | | |
|---|---|---|---|
| 114 | Medicaid Managed Care - United Health Plans of NE (Ocean State Physician's Plan) | B | MCD-MC |
| 115 | Medicaid Managed Care - Pilgrim Health Care | B | MCD-MC |
| 116 | Medicaid Managed Care-Tufts Associated Health Plan | B | MCD-MC |
| 117 | Invalid (no replacement) | | |
| 118 | Medicaid Mental Health & Substance Abuse Plan - Mass Behavioral Health Partnership | B | MCD-MC |
| 119 | Medicaid Managed Care Other (not listed elsewhere) *** | B | MCD-MC |
| 120 | Out-of-State Medicaid | 5 | GOV |
| 121 | Medicare | 3 | MCR |
| 122 | Invalid (replaced by #234) | | |
| 123 | Invalid (no replacement) | | |
| 124 | Invalid (replaced by # 222) | | |
| 125 | Medicare HMO - Fallon Senior Plan | F | MCR-MC |
| 126 | Invalid (replaced by #230) | | |
| 127 | Medicare HMO - Health New England Medicare Wrap ** | F | MCR-MC |
| 128 | Medicare HMO - HMO Blue for Seniors ** | F | MCR-MC |
| 129 | Medicare HMO - Kaiser Medicare Plus Plan ** | F | MCR-MC |
| 130 | Invalid (replaced by #232 and 233) | | |
| 131 | Medicare HMO - Pilgrim Enhance 65 ** | F | MCR-MC |
| 132 | Medicare HMO - Matthew Thornton Senior Plan | F | MCR-MC |
| 133 | Medicare HMO -Tufts Medicare Supplement (TMS) | F | MCR-MC |
| 134 | Medicare HMO - Other (not listed elsewhere) *** | F | MCR-MC |
| 135 | Out-of-State Medicare | 3 | MCR |
| 136 | BCBS Medex ** | 6 | BCBS |
| 137 | AARP/Medigap supplement ** | 7 | COM |
| 138 | Banker's Life and Casualty Insurance ** | 7 | COM |
| 139 | Bankers Multiple Line ** | 7 | COM |
| 140 | Combined Insurance Company of America ** | 7 | COM |
| 141 | Other Medigap (not listed elsewhere) *** | 7 | COM |
| 142 | Blue Cross Indemnity | 6 | BCBS |
| 143 | Free Care | 9 | FC |
| 144 | Other Government | 5 | GOV |
| 145 | Self-Pay | 1 | SP |
| 146 | Worker's Compensation | 2 | WOR |
| 147 | Other Commercial (not listed elsewhere) *** | 7 | COM |
| 148 | Other HMO (not listed elsewhere) *** | 8 | HMO |
| 149 | PPO and Other Managed Care (not listed elsewhere) *** | E | PPO |
| 150 | Other Non-Managed Care (not listed elsewhere) *** | 0 | OTH |
| 151 | CHAMPUS | 5 | GOV |
| 152 | Foundation | 0 | OTH |
| 153 | Grant | 0 | OTH |
| 154 | BCBS Other (Not listed elsewhere) *** | 6 | BCBS |
| 155 | Blue Cross Managed Care Other(Not listed elsewhere)*** | C | BCBS-MC |
| 156 | Out of state BCBS | 6 | BCBS |
| 157 | Metrahealth - PPO (United Health Care of NE) | D | COM-MC |
| 158 | Metrahealth - HMO (United Health Care of NE) | D | COM-MC |

| | | | |
|---|---|---|---|
| 159 | None (Valid only for Secondary Source of Payment) | N | NONE |
| 160 | Blue Choice (includes Healthflex Blue) - POS | C | BCBS-MC |
| 161 | Aetna Managed Choice POS | D | COM-MC |
| 162 | Great West Life POS | D | COM-MC |
| 163 | United Healthcare Insurance Company - POS (New for 1997) | D | COM-MC |
| 164 | Healthsource CMHC Plus POS | J | POS |
| 165 | Healthsource New Hampshire POS (self-funded) | J | POS |
| 166 | Private Healthcare Systems POS | J | POS |
| 167 | Fallon POS | J | POS |

| | | | |
|---|---|---|---|
| 168 | Reserved | | |

| | | | |
|---|---|---|---|
| 169 | Kaiser Added Choice | J | POS |
| 170 | US Healthcare Quality POS | J | POS |
| 171 | CIGNA POS | D | COM-MC |
| 172 | Metrahealth - POS (United Health Care of NE) | D | COM-MC |

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|---|---|---|---|
| 173-180 | Reserved | | |

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|---|---|---|---|
| 181 | First Allmerica Financial Life Insurance EPO | D | COM-MC |
| 182 | UniCare Preferred Plus Managed Access EPO | D | COM-MC |
| 183 | Pioneer Health Care EPO | K | EPO |
| 184 | Private Healthcare Systems EPO | K | EPO |

| | | | |
|---|---|---|---|
| 185 -198 | Reserved | | |

| | | | |
|---|---|---|---|
| 199 | Other EPO (not listed elsewhere) *** | K | EPO |
| 200 | Hartford Life Insurance Co ** | 7 | COM |
| 201 | Mutual of Omaha ** | 7 | COM |
| 202 | New York Life Insurance ** | 7 | COM |
| 203 | Principal Financial Group (Principal Mutual Life) | 7 | COM |
| 204 | Christian Brothers Employee | 7 | COM |
| 207 | Network Health (Cambridge Health Alliance MCD Program) | B | MCD-MC |
| 208 | HealthNet (Boston Medical Center MCD Program) | B | MCD-MC |

| | | | |
|---|---|---|---|
| 205 209 | Reserved | | |

| | | | |
|---|---|---|---|
| 210 | Medicare HMO - Pilgrim Preferred 65 ** | F | MCR-MC |
| 211 | Medicare HMO - Neighborhood Health Plan Senior Health Plus ** | F | MCR-MC |
| 212 | Medicare HMO - Healthsource CMHC Central Care Supplement ** | F | MCR-MC |

| | | | |
|---|---|---|---|
| 213 -219 | Reserved | | |

| | | | |
|---|---|---|---|
| 220 | Medicare HMO - Blue Care 65 | F | MCR-MC |
| 221 | Medicare HMO - Harvard Community Health Plan 65 | F | MCR-MC |
| 222 | Medicare HMO - Healthsource CMHC | F | MCR-MC |

| | | | |
|---|---|---|---|
| 223 | Medicare HMO - Harvard Pilgrim Health Care of New England Care Plus | F | MCR-MC |
| 224 | Medicare HMO - Tufts Secure Horizons | F | MCR-MC |
| 225 | Medicare HMO - US Healthcare | F | MCR-MC |

| | | | |
|---|---|---|---|
| 226-229 | Reserved | | |

| | | | |
|---|---|---|---|
| 230 | Medicare HMO - HCHP First Seniority | F | MCR-MC |
| 231 | Medicare HMO - Pilgrim Prime | F | MCR-MC |
| 232 | Medicare HMO - Seniorcare Direct | F | MCR-MC |
| 233 | Medicare HMO - Seniorcare Plus | F | MCR-MC |
| 234 | Medicare HMO - Managed Blue for Seniors | F | MCR-MC |

| | | | |
|---|---|---|---|
| 235-249 | Reserved | | |

| | | | |
|---|---|---|---|
| 250 | CIGNA HMO | D | COM -MC |
| 251 | Healthsource CMHC HMO | 8 | HMO |

| | | | |
|---|---|---|---|
| 252-269 | Reserved | | |

| | | | |
|---|---|---|---|
| 270 | UniCare Preferred Plus PPO | D | COM - MC |
| 271 | Hillcrest HMO | 8 | HMO |

| | | | |
|---|---|---|---|
| 272 | Auto Insurance | T | AI |
| 990 | Free Care – co-pay, deductible, or co-insurance (when billing for free care services use #143) | 9 | FC |

** Supplemental Payer Source
*** Please list under the specific carrier when possible

**SUPPLEMENTAL PAYER SOURCES**
**USE AS SECONDARY PAYER SOURCE ONLY**:

| | | | |
|---|---|---|---|
| 137 | AARP/Medigap Supplement | 7 | COM |
| 138 | Banker's Life and Casualty Insurance | 7 | COM |
| 139 | Bankers Multiple Line | 7 | COM |
| 136 | BCBS Medex | 6 | BCBS |
| 140 | Combined Insurance Company of America | 7 | COM |
| 200 | Hartford Life Insurance co. | 7 | COM |
| 127 | Medicare HMO -Health New England Medicare Wrap | F | MCR-MC |
| 212 | Medicare HMO - Healthsource CMHC Central Care Supplement | F | MCR-MC |
| 128 | Medicare HMO -HMO Blue for Seniors | F | MCR-MC |
| 129 | Medicare HMO-Kaiser Medicare Plus Plan | F | MCR-MC |
| 131 | Medicare HMO-Pilgrim Enhance 65 | F | MCR-MC |
| 210 | Medicare HMO-Pilgrim Preferred 65 | F | MCR-MC |
| 201 | Mutual of Omaha | 7 | COM |
| 211 | Neighborhood Health Plan Senior Health Plus | F | MCR-MC |
| 202 | New York Life Insurance Company | 7 | COM |

| | | | |
|---|---|---|---|
| 141 | Other Medigap (not listed elsewhere) *** | 7 | COM |
| 133 | Medicare HMO -Tufts Medicare Supplement (TMS) | F | MCR-MC |

**(i)**

| * VESTA CODE | * VETERAN STATUS DEFINITION |
|---|---|
| 1 | YES |
| 2 | NO (includes never in mililtary, currently in active duty, national guard or reservist with 6 months or less active duty) |
| 3 | Not applicable |
| 4 | Not Determined (unable to obtain information) |

(j)

| *DNR CODE | DO NOT RESUSCITATE STATUS DEFINITION |
|---|---|
| 1 | DNR order written |
| 2 | Comfort measures only |
| 3 | No DNR order or comfort measures ordered |

(k)

| ED Flag Code | Admitted ED Patient Definition |
|---|---|
| 0 | Not admitted from the ED, no ED visit reflected in this record |
| 1 | Not admitted from the ED, but ED visit(s) reflected in this record |
| 2 | Admitted from the ED |
| | |

Example: If a patient is not admitted as an inpatient directly from the ED, but a recent ED visit is included in this record because of “payment window” rules, choose code 1.

(l)

| Observa-tion Stay Flag Code | Admitted Observation Patient Flag |
|---|---|
| Y | Admitted from outpatient observation stay |
| N | Not admitted from outpatient observation stay |

Example: If a patient has an ED visit, then is held for outpatient observation, and then is admitted as an inpatient from

observation, use ED flag code 1 as well as Observation Stay Flag code Y.

**(2) Record Types '30' and '40'**

**(a) Routine Accommodations:**

| Revenue Center | | Revenue Code | Units of Service |
|---|---|---|---|
| 1. | Medical/Surgical | 111 (Includes codes: 111, 121,131, 141, 151.) | Days |
| 2. | Obstetrics | 112 (Includes codes: 112, 122,132, 142, 152. | Days |
| 3. | Pediatrics | 113 (Includes codes: 113, 123, 133, 143, 153.) | Days |
| 4. | Psychiatric | 114 (Includes codes: 114, 124, 134, 144, 154.) | Days |
| 5. | Hospice | 115 (Includes codes: 115, 125, 135, 145, 155.) | Days |
| 6. | Detoxification | 116 (Includes codes: 116, 126, 136, 146, 156.) | Days |
| 7. | Oncology | 117 (Includes codes: 117, 127, 137, 147, 157.) | Days |
| 8. | Rehabilitation | 118 (Includes codes: 118, 128, 138, 148, 158.) | Days |
| 9. | Other | 119 (Includes codes: 119, 129, 139, 149, 159.) | Days |
| 10. | Nursery | 170 | Days |

**(b) Special Care Accommodations:**

| Revenue Center | | Revenue Code | Units of Service |
|---|---|---|---|
| 1. | Neo-natal ICU | 175 (Includes codes: 173 &174.) | Days |
| 2. | Medical/Surgical ICU | 200 (Includes codes: 201 & 202.) | Days |
| 3. | Pediatric ICU | 203 | Days |
| 4. | Psychiatric ICU | 204 | Days |
| 5. | Post Care ICU | 206 | Days |
| 6. | Burn Unit | 207 | Days |
| 7. | Trauma ICU | 208 | Days |
| 8. | Other ICU | 209 | Days |
| 9. | Coronary Care Unit | 210 | Days |
| 10. | Myocardial | 211 | Days |

| | | | |
|---|---|---|---|
| | | (Includes codes: 170, 171, 172, 179.) | |
| 11. | Chronic | 192 | Days |
| 12. | Subacute | 196 | Days |
| 13. | TCU | 197 | Days |
| 14. | SNF | 198 | Days |

| | | | |
|---|---|---|---|
| | Infarction | | |
| 11. | Pulmonary Care | 212 | Days |
| 12. | Heart Transplant | 213 | Days |
| 13. | Post Coronary Care | 214 | Days |
| 14. | Other Coronary Care | 219 | Days |

**(c) Ancillary Services:**

| Revenue Center | | Revenue Code | Units of Service |
|---|---|---|---|
| 1. | Special Charges | 220 | Zeros |
| 2. | Incremental Nursing Charge Rate | 230 | Zeros |
| 3. | All Inclusive Ancillary | 240 | Zeros |
| 4. | Pharmacy | 250 | Zeros |
| 5. | IV Therapy | 260 | Zeros |
| 6. | Medical/Surgical Supplies and Devices | 270 | Zeros |
| 7. | Oncology | 280 | Zeros |
| 8. | Durable Medical Equipment | 290 | Zeros |
| 9. | Laboratory | 300 | Zeros |
| 10. | Laboratory Pathological | 310 | Zeros |
| 11. | Diagnostic Radiology | 320 | Zeros |
| 12. | Therapeutic Radiology | 330 | Zeros |
| 13. | Nuclear Medicine | 340 | Zeros |
| 14. | CAT Scan | 350 | Zeros |
| 15. | Operating Room Services | 360 | Zeros |
| 16. | Anesthesia | 370 | Zeros |
| 17. | Blood | 380 | Zeros |
| 18. | Blood Storage and Processing | 390 | Zeros |
| 19. | Other Imaging Services | 400 | Zeros |
| 20. | Respiratory Services | 410 | Zeros |
| 21 | Physical Therapy | 420 | Zeros |
| 22. | Occupational Therapy | 430 | Zeros |
| 23. | Speech-Language Pathology | 440 | Zeros |
| 24. | Emergency Room | 450 | Zeros |
| 25. | Pulmonary Function | 460 | Zeros |
| 26. | Audiology | 470 | Zeros |
| 27. | Cardiology | 480 | Zeros |
| 28. | Ambulatory Surgical Care | 490 | Zeros |
| 29. | Outpatient Services | 500 | Zeros |

| | | | |
|---|---|---|---|
| 30. | Clinics | 510 | Zeros |
| 31. | Free-Standing Clinic | 520 | Zeros |
| 32. | Osteopathic Services | 530 | Zeros |
| 33. | Ambulance | 540 | Zeros |
| 34. | Skilled Nursing | 550 | Zeros |
| 35. | Medical Social Services | 560 | Zeros |
| 36. | Home Health Aide (Home Health) | 570 | Zeros |
| 37. | Other Visits (Home Health) | 580 | Zeros |
| 38. | Units of Service (Home Health) | 590 | Zeros |
| 39. | Oxygen (Home Health) | 600 | Zeros |
| 40. | MRI | 610 | Zeros |
| 41. | Medical/Surgical Supplies - Extension of 270 | 620 | Zeros |
| 42. | Drugs Requiring Specific Identification | 630 | Zeros |
| 43. | Home IV Therapy Services | 640 | Zeros |
| 44. | Hospice Service | 650 | Zeros |
| 45. | Respite Care (HHA Only) | 660 | Zeros |
| 46. | Not Assigned | 670 | |
| 47. | Not Assigned | 680 | |
| 48. | Not Assigned | 690 | |
| 49. | Cast Room | 700 | Zeros |
| 50. | Recovery Room | 710 | Zeros |
| 51. | Labor Room/Delivery | 720 | Zeros |
| 52. | EKG/ECG (Electrocardiogram) | 730 | Zeros |
| 53. | EEG (Electroencephalogram) | 740 | Zeros |
| 54. | Gastro-Intestinal Services | 750 | Zeros |
| 55. | General Treatment or Observation Room | 760 | Zeros |
| 56. | Treatment Room | 761 | Zeros |
| 57. | Observation Room | 762 | Hours |
| 58. | Other Observation Room | 769 | Hours |
| 59. | Preventative Care Services | 770 | Zeros |
| 60. | Not Assigned | 780 | Zeros |
| 61. | Lithotripsy | 790 | Zeros |
| 62. | Inpatient Renal Dialysis | 800 | Zeros |
| 63. | Organ Acquisition | 810 | Zeros |
| 64. | Hemodialysis - Outpatient or Home | 820 | Zeros |
| 65. | Peritoneal Dialysis - Outpatient or Home | 830 | Zeros |
| 66. | Continuous Ambulatory Peritoneal Dialysis - Outpatient or Home | 840 | Zeros |
| 67. | Continuous Cycling Peritoneal Dialysis - Outpatient or Home | 850 | Zeros |
| 68. | Invalid (Reserved for Dialysis | 860 | |

| | | | |
|---|---|---|---|
| | - National Assignment) | | |
| 69. | Invalid (Reserved for Dialysis - National Assignment) | 870 | |
| 70. | Miscellaneous Dialysis | 880 | Zeros |
| 71. | Other Donor Bank | 890 | Zeros |
| 72. | Psychiatric/Psychological Treatments | 900 | Zeros |
| 73. | Psychiatric/Psychological Services | 910 | Zeros |
| 74. | Other Diagnostic Services | 920 | Zeros |
| 75. | Not Assigned | 930 | |
| 76. | Other Therapeutic Services | 940 | Zeros |
| 77. | Other | 950 | Zeros |
| 78. | Professional Fees | 960 (Includes codes: 960, 961, 962, 963, 964, 969.) | Zeros |
| 79. | Professional Fees | 970 (Includes codes: 970, 971, 972, 973, 974, 975, 976, 977, 978, 979.) | Zeros |
| 80. | Professional Fees | 980 (Includes codes: 980, 981, 982, 983, 984, 985, 986, 987, 988, 989.) | Zeros |
| 81. | Patient Convenience Items | 990 | Zeros |

**(3) Record Type '50'**

| *OTH CARE CODE | *TYPE OF OTHER CAREGIVER DEFINITION |
|---|---|
| 1 | Resident |
| 2 | Intern |
| 3 | Nurse Practitioner |
| 4 | Not used |
| 5 | Physician Assistant |

**(4) Record Type '99'**

| * TYBA CODE | * Type of Batch Definition |
|---|---|
| 11 | Submission of updates to |

| | |
|---|---|
| | existing records. |
| 22 | Submission of additional records (changes to data base) |
| 33 | Replacement of an entire quarter's data, (additions) |
| 99 | Submission of an entire quarter's data (deletions/additions). |

## 17.07: Inpatient Data Quality Standards

(1) The data will be edited for compliance with the edit specifications set forth in 114.1 CMR 17.04. The standards to be employed for rejecting data submissions from hospitals will be based upon the presence of errors in the following data elements categorized A or B:

| Date Element | Record Type(s) | Category |
|---|---|---|
| Record Type | 01, 10, 20, 30, 40, 50, 60, 90, 95, 99 | A |
| Submitter Name | 01 | A |
| Receiver ID | 01 | A |
| DPH Hospital Computer No. | 10 | A |
| Type of Batch | 10, 95 | A |
| Period Starting Date | 10 | A |
| Period Ending Date | 10 | A |
| Medical Record Number | 20, 30, 40, 50, 60, 90 | A |
| Patient Sex | 20 | A |
| Patient Race | 20 | B |
| Patient Birth Date | 20 | A |
| Type of Admission | 20 | B |
| Source of Admission | 20 | B |
| Patient Zip Code | 20 | B |
| Admission Date | 20 | A |
| Discharge Date | 20 | A |
| Veteran Status | 20 | B |
| Primary Source of Payment | 20 | A |
| Patient Status | 20 | A |
| Billing Number | 20 | A |
| Primary Payer Type | 20 | A |
| Claim Certificate Number | 20 | A |
| Patient Social Security Number | 20 | B |
| Birth Weight-grams | 20 | B |
| Secondary Payer Type | 20 | A |
| Employer Zip Code | 20 | B |
| Mother's Social Security Number | 20 | B |
| Mother's Medical Record Number | 20 | A |
| Facility Site Number | 20 | B |
| Primary National Payer Identification Number | 20 | A |
| Secondary National Payer Identification Number | 20 | A |
| Revenue Code | 30,40 | A |

| | | |
|---|---|---|
| Units of Service | 30,40 | A |
| Total Charges (by Revenue Code) | 30,40 | A |
| External Cause of Injury Code | 50 | B |
| Principal Diagnosis Code | 50 | A |
| Associate Diagnosis Code I - XIV | 50 | A |
| Attending Physician License Number (Board of Registration in Medicine No.) | 50 | B |
| Operating Physician License Number (Board of Registration in Medicine No.) | 50 | B |
| Number of ANDs | 50 | A |
| Other Caregiver | 50 | B |
| Attending Physician National Provider Identifier (NPI) | 50 | B |
| ATT NPI Location Code | 50 | B |
| Operating Physician National Provider Identifier (NPI) | 50 | B |
| Operating NPI Location Code | 50 | B |
| Additional Caregiver National Provider Identifier | 50 | B |
| Principal Procedure Code | 60 | A |
| Date of Principal Procedure | 60 | B |
| Significant Procedure I | 60 | A |
| Significant Proc. I Date | 60 | B |
| Significant Procedure II | 60 | A |
| Significant Proc. II Date | 60 | B |
| Significant Procedure III - XIV | 60 | A |
| Physical Record Count | 90 | A |
| Record Type 2x Count | 90 | A |
| Record Type 3x Count | 90 | A |
| Record Type 4x Count | 90 | A |
| Record Type 5x Count | 90 | A |
| Record Type 6x Count | 90 | A |
| Total Charges Spec. Services | 90 | A |
| Total Charges Routine Services | 90 | A |
| Total Charges Ancillaries | 90 | A |
| Total Charges (All Charges) | 90 | A |
| Number of Discharges | 95 | A |
| Total Charges Accommodations | 95 | A |
| Total Charges Ancillaries | 95 | A |
| Submitter EIN | 99 | A |
| Number of Providers on Tape | 99 | A |
| Count of Batches | 99 | A |
| Batch Counts (11, 22, 33, 99) | 99 | A |

(2) All errors will be recorded for each patient discharge. A patient discharge will be rejected from updating the data base (with a hard copy of the discharge data generated) under the following conditions:

(a) Presence of one or more error flags for Category A elements.

(b) Presence of two or more errors for Category B elements.

(3) A provider Batch will be rejected and returned to submitter if:

(a) any Category A elements of Provider Record (Record Type 10) or Provider Batch Control Record (Record Type = 95) are in error or

(b) if 1% or more of discharges are rejected or

(c) if 50 consecutive records are rejected.

(4) An entire data tape for a hospital (or processor providing discharge data for more than one provider) will be rejected under any of the following conditions:

(a) Any Category A errors on Label Record (Record Type = 01).

(b) Any Category A errors on Tape Control Record (Record Type = 99).

(5) Acceptance of data tapes under the edit check procedures identified in 114.1 CMR 17.07 shall not be deemed acceptance of the factual accuracy of the data contained therein.

## 17:08: Outpatient Observation Data Specifications

Outpatient Observation Data reported includes patients who receive observation services and who are not admitted. An example of an outpatient observation stay might be a post surgical day care patient who, after a normal recovery period, continues to require hospital observation, and then is released from the hospital. The Outpatient Observation Data is subject to the same Data Submission Arrangements, Submission Dates, Compliance and Protection of Data as the inpatient discharge data and as specified in 17.09, 17.10, 17.11, 17.12, 17.13, 17.14 respectively.

The data for outpatient observation departures must be submitted in an ASCII comma delimiter or DBF file format contained on 1.44 MB diskette(s). A zip file format is acceptable. Separate diskettes must be filed for each quarter for each hospital. Outpatient Observation Data consisting of multiple quarters may not be placed on the same diskette. Diskettes received containing data with multiple quarters cannot be processed by the Division, thus are not acceptable. Inclusion of a patient's Outpatient Observation Data in a quarterly submission shall be based on the patient's ending date of service which must fall within the quarter to be submitted.

Hospitals submitting data in an ASCII comma delimiter format must submit comma delimited data using the following format specifications:

Text Delimiter: Double Quote (‘’)
Field Separator: Comma (,)

Carriage return must be placed at the end of each record.
The number of characters between quotes must not exceed the maximum length of a field.

ASCII Comma Delimiter Format Example: “20XX”,””,”nnnnnnnnn”,”nnnnnnnnn”,”nnnnn”

In the future, the Division may allow for submission of data by other media types or varying modes of data submission.

The media must contain the following data elements in the specified format:

## 1. Outpatient Observation Data Record Specifications:

| Field No | Field Name: | Data Type: | Length: | Short Description and Edit Specifications: | Error Category |
|---|---|---|---|---|---|
| 1. | Hos_ID | Character | 4 | Hospital DPH number:<br>- Must be present<br>- Must be numeric | A |
| 2. | MultiSiteN | Character | 1 | Hospital's designated number for multiple sites merged under one DPH number.<br>- May be present | |
| 3. | Pt_ID | Character | 9 | - Must be present<br>- Must be valid social security number or '000000001' if unknown | A |
| 4. | MR_N | Character | 10 | Patient's medical record number:<br>- Must be present | A |
| 5. | Acct_N | Character | 17 | Hospital billing number for the patient:<br>- Must be present | A |
| 6. | MOSS | Character | 9 | Mother's social security number for infants up to 1 year old.<br>- Must be present for infants one year old or less. | B |
| 7. | MCD_ID | Character | 17 | Medicaid Claim Certificate Number:<br>- Must be present if Payer Source Code has a Medicaid or Medicaid Managed Care Payer Type as specified in 114.1 CMR 17.06(1)(g) and (h).<br>- Must be blank if payer source is not a Medicaid plan. | A |
| 8. | DOB | Character | ccyymmdd | Patient date of birth:<br>- Must be present<br>- Must be valid date except 99 acceptable in month & day fields<br>- Must not be later than the begin date | A |
| 9. | Sex | Character | 1 | Patient's sex:<br>- Must be present<br>- Must be valid code as specified in 114.1 CMR 17.08 (2) | A |
| 10. | Race | Character | 1 | Patient's race:<br>- Must be present<br>- Must be valid code as specified in 114.1 CMR 17.08 (2) | B |
| 11. | Zip_Code | Character | 5 | Patient's zip code:<br>- Must be present<br>- Must be numeric<br>- Must be 0's if zip code is unknown<br>- Must be 7's if foreign zip code | B |
| 12. | Ext_ZCode | Character | 4 | Patient's 4 digit zip code extension: | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | - May be present<br>- Must be numeric<br>- If not present, leave blank | |
| 13. | Beg_Date | Date | ccyymmdd | Patient's beginning service date:<br>- Must be present<br>- Must be valid date<br>- Must be less than or equal to end date | A |
| 14. | End_Date | Date | ccyymmdd | Patient's ending service date:<br>- Must be present<br>- Must be valid date<br>- Must be greater than or equal to begin date | A |
| 15. | Obs_Time | Character | 4 | Initial encounter time of day.<br>- Must be present<br>- Must range from 0000 to 2400 | B |
| 16. | Ser_Unit | Character | 6 | Unit of service is hours:<br>- Must be present<br>- Include decimal point with 2 places (for example 100.25) | A |
| 17. | Obs_Type | Character | 1 | Patient's type of visit status:<br>- Must be present<br>- Must be valid code as specified in 114.1 CMR 17.08 (2) | B |
| 18. | Obs_1Srce | Character | 1 | Originating referring or transferring source for Observation visit:<br>- Must be present<br>- Must be valid code as specified in 114.1 CMR 17.08 (2) | B |
| 19. | Obs_2Srce | Character | 1 | Secondary referring or transferring source for Observation visit:<br>- Must be present, if applicable<br>- If not present, leave blank<br>- Must be valid code as specified in 114.1 CMR 17.08 (2) | B |
| 20. | Dep_Stat | Character | 1 | Patient's departure status:<br>- Must be present<br>- Must be valid code as specified in 114.1 CMR 17.08 (2) | A |
| 21. | Payr_Pri | Integer | 3 | Patient's primary source of payment:<br>- Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(h) | A |
| 22. | Payr_Sec | Integer | 3 | Patient's secondary payment source: | A |

| | | | | | |
|---|---|---|---|---|---|
| | | | | - Must be present<br>- Must be valid code as specified in 114.1 CMR 17.06(1)(h)<br>- If not applicable, must be coded as "159" for *none* as specified in 17.06(1)(h). | |
| 23. | Charges | Numeric | 10 | - Must be present<br>- Must be numeric:<br>- Must be whole numbers, no decimals.<br>- Must be rounded up to the nearest dollar. ($337.59 should be reported as $338) | A |
| 24. | Surgeon | Character | 6 | Patient's surgeon for this visit:<br>- If present, must be a valid and current Mass. Board of Registration in Medicine license number or<br>- Must be "DENSG", "PODTR", "OTHER" or "MIDWIF" | B |
| 25. | Att_MD | Character | 6 | Patient's attending physician:<br>- Must be present<br>- Must be a valid and current Mass. Board of Registration in Medicine license number, or<br>- Must be "DENSG", "PODTR" "OTHER" or "MIDWIF" | B |
| 26. | Oth_Care | Character | 1 | Other caregiver:<br>- May be present<br>- If not present, leave blank<br>- If present, must be valid code as specified in 114.1 CMR 17.08 (2) | B |
| 27. | PDX | Character | 5 | Patient's principal diagnosis:<br>- Must be present<br>- Must be valid ICD-9-CM code[+] in diagnosis file (exclude decimal point) | A |
| 28. | Assoc_DX1 | Character | 5 | Patient's first associated diagnosis:<br>- If present, PDX must be present<br>- Must be valid ICD-9-CM code[+] in diagnosis file (exclude decimal point) | A |
| 29. | Assoc_DX2 | Character | 5 | Patient's second associated diagnosis:<br>- If present DX1 must be present<br>- Must be valid ICD-9-CM code[+] in diagnosis file (exclude decimal point) | A |
| 30. | Assoc_DX3 | Character | 5 | Patient's third associated diagnosis:<br>- If present, DX2 must be present | A |

| | | | | | |
|---|---|---|---|---|---|
| | | | | - Must be valid ICD-9-CM code+ in diagnosis file (exclude decimal point) | |
| 31. | Assoc_DX4 | Character | 5 | Patient's fourth associated diagnosis:<br>- If present, DX3 must be present<br>- Must be valid ICD-9-CM code+ in diagnosis file (exclude decimal point) | A |
| 32. | Assoc_DX5 | Character | 5 | Patient's fifth associated diagnosis:<br>- If present, DX4 must be present<br>- Must be valid ICD-9-CM code+ in diagnosis file (exclude decimal point) | A |
| 33. | P_PRO | Character | 4 | Patient's Principal Procedure:<br>- If entered must be valid ICD-9-CM code+ (exclude decimal point) | A |
| 34. | P_PRODATE | Date | ccyymmdd | Date of patient's Principal Procedure:<br>- Must be present if P_PRO code is present<br>- Must be a valid date<br>- Must not be earlier than 3 days prior to beginning date of service<br>- Must not be later than departure date (ending date of service) | B |
| 35. | Assoc_PRO1 | Character | 4 | Patient's first associated procedure:<br>- If present, P_PRO code must be present<br>- If entered, must be a valid ICD-9-CM code+ (exclude decimal point) | A |
| 36. | AssocDATE1 | Date | ccyymmdd | Date of patient's first Associated Procedure:<br>- Must be present if Assoc_PRO1 code is present<br>- Must be a valid date<br>- Must not be earlier than 3 days prior to the beginning date of service<br>- Must not be later than the ending date of service | B |
| 37. | Assoc_PRO2 | Character | 4 | Patient's second Associated Procedure:<br>- If present, Assoc_PRO1 code must be present.<br>- If entered must be valid ICD-9-CM code+ (exclude decimal point) | A |
| 38. | AssocDATE2 | Date | ccyymmdd | Date of patient's second associated procedure:<br>- Must be present if Assoc_PRO2 code is present<br>- Must be a valid date | B |

| | | | | | |
|---|---|---|---|---|---|
| | | | | - Must not be earlier than 3 days prior to the beginning date of service<br>- Must not be later the ending date of service | |
| 39. | Assoc_PRO3 | Character | 4 | Patient's third associated procedure:<br>- If present, Assoc_PRO2 code must be present.<br>- If entered must be valid ICD-9-CM code+ (exclude decimal point) | A |
| 40. | AssocDATE3 | Date | ccyymmdd | Date of patient's third associated procedure:<br>- Must be present if Assoc_PRO3 code is present<br>- Must be a valid date<br>- Must not be earlier than 3 days prior to the beginning date of service<br>- Must not be later than ending date of service | B |
| 41. | CPT1 | Character | 5 | Patient's first CPT code:<br>- If entered must be valid CPT code | A |
| 42. | CPT2 | Character | 5 | Patient's second CPT code:<br>- If entered must be valid CPT code<br>- If present, CPT1 must be present | A |
| 43. | CPT3 | Character | 5 | Patient's third CPT code:<br>- If entered must be valid CPT code<br>- If present, CPT2 must be present | A |
| 44. | CPT4 | Character | 5 | Patient's fourth CPT code:<br>- If entered must be valid CPT code<br>- If present, CPT3 must be present | A |
| 45. | CPT5 | Character | 5 | Patient's fifth CPT code:<br>- If entered must be valid CPT code<br>- If present, CPT4 must be present | A |
| 46. | ED_Flag | Character | 1 | Flag to indicate whether patient was admitted to this outpatient observation stay from this facility's ED<br>-Must be present | A |

+ = All ICD-9-CM should be reported as the exact code excluding the decimal point. Zeros contained in the code should be reported. For example, the code '001.0' should be reported as '0010'.

Note: Any field not required and not present should be left blank.

## 2. Outpatient Observation Data Code Tables:

| No. | Field Name: | Description: |
|---|---|---|
| 1. | Hos_ID | Hospital Department of Public Health number. |

| | | |
|---|---|---|
| 2. | MultiSiteN | Optional field for a hospital's determined number used to distinguish multiple sites that fall under one DPH number. |
| 3. | Pt_ID | Patient social security number. |
| 4. | MR_N | Patient's hospital medical record number. |
| 5. | Acct_N | Hospital's billing number for the patient. |
| 6. | MOSS | Mother's social security number for infants up to one year old or less. |
| 7. | MCD_ID | Medicaid Claim Certificate Number. |
| 8. | DOB | Birth century, year, month, and day. |
| 9. | Sex | M=male F=female U=unknown. |
| 10. | Race | 1=White 2=Black 3=Asian 4=Hispanic 5=Native American 6=Other 9=Unknown |
| 11. | Zip_Code | Patient's residential 5 digit zip code. |
| 12. | Ext_Zcode | Patient's residential 4 digit zip code extension. |
| 13. | Beg_Date | Century, year, month and day when service begins. |
| 14. | End_Date | Century, year, month and day when service ends. |
| 15. | Obs_Time | Initial Observation encounter time. The time the patient became an Observation Stay patient. |
| 16. | Ser_Unit | The amount of time the patient has spent as an Observation Stay patient. The unit of service for Observation Stay is hours. |
| 17. | Obs_Type | Observation Visit Status: 1 = Emergency, 2 = Urgent, , 3 = Elective, 4 = Newborn, 5 = Information Not Available. |
| 18. | Obs_1Srce | Originating Observation Visit Source:<br>1 = Direct Physician Referral, 2 = Within Hospital Clinic Referral, 3 = Direct Health Plan Referral, 4 = Transfer from Acute Care Hospital, 5 = Transfer from SNF, 6 = Transfer from ICF, 7 = Outside Hospital ER Transfer, 8 = Court/Law Enforcement, 9 = Other, 0 = Inform. Not Available, L = Outside Hospital Clinic Referral, M= Walk-in/Self Referral, R = Inside Hospital ER Transfer, T = Transfer from another Institution's SDS, W = Extramural Birth, Y = Within Hospital SDS Transfer.<br><br>Example: If a patient is transferred from a SNF to the hospital's Clinic and then becomes an Observation Stay status, the Originating Observation Source would be "5 - Transfer from SNF". |
| 19. | Obs_2Srce | Secondary Observation Visit Source:<br>1 = Direct Physician Referral, 2 = Within Hospital Clinic Referral, 3 = Direct Health Plan Referral, 4 = Transfer from Acute Care Hospital, 5 = Transfer from SNF, 6 = Transfer from ICF, 7 = Outside Hospital ER Transfer, 8 = Court/Law Enforcement, 9 = Other, 0 = Inform. Not Available, L = Outside Hospital Clinic Referral, M= Walk-in/Self Referral, R = Inside Hospital ER Transfer, T = Transfer from another institution's SDS, W = Extramural Birth, Y = Within Hospital SDS Transfer. |

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|---|---|---|
| | | Example: If a patient is transferred from a SNF to the hospital's Clinic and then becomes an Observation Stay status, the Secondary Observation Source would be "2 - Within Hospital Clinic Transfer". |
| 20. | Dep_Stat | Patient Disposition (Departure Status): 1 = Routine,<br>2 = Adm to Hospital, 3 = Transferred, 4 = AMA, 5 = Expired. |
| 21. | Payr_Pri | Primary Source of Payment. Refer to the Payer Source description listed in 114.1 CMR 17.06(1)(h). |
| 22. | Payr_Sec | Secondary Source of Payment. Refer to the Payer Source description listed in 114.1 CMR 17.06(1)(h). If there is no secondary source of payment, use payer source code #159 - NONE as listed in the Payer Source description table. |
| 23. | Charges | Grand total of all charges associated with the patient's observation stay. The total charge amount should be rounded up to the nearest dollar. For example, $3562.79 should be reported as $3563. |
| 24. | Surgeon | Surgeon's Mass. Board of Registration in Medicine License Number or "DENSG", "PODTR", "OTHER", or "MIDWIF" for Dental Surgeon, Podiatrist, Other (i.e. non-permanent licensed physicians) or Midwife, respectively. |
| 25. | Att_MD | Attending Physician's Mass. Board of Registration in Medicine License Number or "DENSG", "PODTR", "OTHER", or "MIDWIF" for Dental Surgeon, Podiatrist, Other (i.e. non-permanent licensed physicians) or Midwife, respectively. |
| 26. | Oth_Care | Other primary caregiver responsible for patient's care:<br>1 = Resident, 2 = Intern, 3 = Nurse Practitioner, 4 = Not Used,<br>5 = Physician Assistant. |
| 27. | PDX | ICD-9-CM Principal Diagnosis excluding decimal point. |
| 28-32 | Assoc_DX | ICD-9-CM Associated Diagnosis, up to five associated diagnoses excluding the decimal point. |
| 33. | P_PRO | Principal ICD-9-CM Procedure excluding decimal point. |
| 34. | P_PRODATE | Date (century, year, month and day) of patient's principal procedure. |
| 35.<br>36.<br>37. | Assoc_PRO | ICD-9-CM Associated Procedures, up to three associated procedures excluding the decimal point. |
| 38.<br>39.<br>40 | AssocDATE | Date(s) (century, year, month and day) of patient's associated procedures, up to three. |
| 41-45. | CPT | CPT4, up to five CPT codes. |
| 46. | ED_Flag | 0=not admitted to observation from the ED, no ED visit reflected on this record; 1= not admitted to observation from the ED, but ED visit(s) reflected in this record; 2=admitted to observation from the ED. |

**3. Observation Data Quality Standards.**

The data will be edited for compliance with the edit specifications set forth in 114.1 CMR

17.08. The standards to be employed for rejecting data submissions from hospitals will be based upon the presence of Category A or B errors as listed in 17:08 for each data element under the following conditions:

(a) All errors will be recorded for each patient discharge. A patient discharge will be rejected from updating the data base (with a hard copy of the discharge data generated) if there is:

(i) Presence of one or more error flags for Category A elements.

(ii) Presence of two or more errors for Category B elements.

(b) A hospital data submission will be rejected and media returned to the submitter if:

(i) 1% or more of discharges are rejected or

(ii) 50 consecutive records are rejected.

(c) Acceptance of data under the edit check procedures identified in 114.1 CMR 17.08 shall not be deemed acceptance of the factual accuracy of the data contained therein.

## 17.09: Data Submission Requirements

(1) Each general acute care hospital or their designated agent shall provide the required data on the required media in accordance with the record descriptions, specifications, definitions and codes. Hospitals shall submit the data directly to the Division or, in the alternative, to a suitable agent as designated by the Division for collecting, processing and/or holding the data.

(a) For Inpatient Data record descriptions, specifications, definitions and codes are required as specified in 114.1 CMR 17.03,17.04,17.05 and 17.06, respectively; and

(b) For Outpatient Observation Data record descriptions, specifications, definitions and codes are required as specified in 114.1 CMR 17.08, and

(c) For outpatient emergency department visit data, specifications, definitions and codes are required as specified in technical and data specifications issued by administrative bulletin pursuant to 114.1 CMR 17.15.

(2) Resubmissions of data required by the Division for the purposes of adding records, amending data elements or otherwise making modifications to a previous data submission must meet the following provisions:

(a) Resubmissions shall conform with the requirements of the pertinent specifications: 114.1 CMR 17.03, 17.04, 17.05 and 17.06, or 17.08, or for outpatient emergency department data, 114.1 CMR 17.15 and administrative bulletins issued pursuant to 114.1 CMR 17.15; and

(b) For inpatient discharge records, the resubmission of data shall be a single batch of all patient records and control records as noted in 114.1 CMR 17.03 with the appropriate amendments or additions. Resubmissions of outpatient observation stay and emergency department visit data must also be in a single batch, and

(c) The data changes embodied in the resubmitted discharge data are only those required by the Division pursuant to 114.1 CMR 17.09(2), or those approved by the Division pursuant to 114.1 CMR 17.09(3)(a).

(3) Resubmissions of data initiated by a hospital for the purposes of adding records, amending data elements or otherwise making modifications to a previous data submission must meet the following provisions:

(a) The hospital petitions and receives the Division's written approval to resubmit case mix tapes or diskettes. The petition shall include a statement of the reasons for the changes and the changes to be made, and

(b) Resubmissions shall conform with the requirements of 114.1 CMR 17.03, 17.04, 17.05, 17.06, 17.08, 17.10, and for outpatient emergency department data, 114.1 CMR 17.15 and administrative bulletins issued pursuant to 114.1 CMR 17.15, and

(c) For inpatient discharge records, the resubmission of data shall be a single batch of all patient records and control records as noted in 114.1 CMR 17.03 with the appropriate amendments or additions. Resubmissions of outpatient observation stay and outpatient emergency department visit data must also be in a single batch, and

(d) The data changes embodied in the resubmitted discharge data are only those approved by the Division pursuant to 114.1 CMR 17.09(3)(a), or those required by the Division pursuant to 114.1 CMR 17.09(2).

(4) Submission of data for newly merged facilities should be submitted using each individual facility's Massachusetts Department of Public Health (MDPH) Facility Number prior to the merge. Merged hospitals can continue to file separate tapes for each facility using the individual's MDPH Facility Number, or one tape per merged entity can be submitted using separate batches for each facility as outlined in 17.03(3). The transmittal sheet should clearly indicate which facilities are contained on the tape and which batch corresponds to each facility.

This section codifies the Division's policy on merged facilities which was communicated to hospitals in a letter dated June 27, 1997.

## 17.10: Submission Dates

(1) (a) The submission of inpatient, outpatient observation, and outpatient emergency department visit data for patient discharges within each three month period shall be submitted no later than 75 days following the end of the reporting period. Quarterly submissions are due at the Division on March 16, June 14, September 13, and December 14 for all hospitals.

(b) For emergency department visit data only, data for the period January 1, 2000 to September 30, 2001 shall be submitted as soon as possible after March 16, 2002, but no later than July 1, 2002. Data for this period will be held to less strict data standards as described in 114.1 CMR 17.15(3).
(2) Case mix data resubmitted pursuant to 114.1 CMR 17.09(2) shall be submitted no later than 30 days following the date of notification of the requirement to resubmit. Except as provided below, case mix data resubmitted pursuant to 114.1 CMR 17.09(3) shall be submitted no later than 30 days following the due date of the original case mix data submission as specified in 114.1 CMR 17.10(1). Case mix data that is resubmitted in response to the results of the Division's mid-year or year end case mix verification or profile project, which is necessary to implement 114.5 CMR 2.00, shall be submitted no later than 30 days following the mailing of the Verification Report. (3) The Division may, for good cause, grant an extension in time to a hospital for submitting inpatient, outpatient observation, or outpatient emergency department discharge data.

## 17.11: Compliance

(1) Any general acute care hospital not complying with 114.1 CMR 17.00 shall be subject to the penalties specified in M.G.L.c. 118G, ss. 8, 10 and 114.1 CMR 36.09 (14). The Division shall consider a general acute care hospital out of compliance with 114.1 CMR 17.00 in the following circumstances:

(a) more than 1% of the hospital's records, on a quarterly basis, are excluded from the data base by the Division because the records do not pass critical edit checks as specified in 114.1 CMR 17.04,

17.07, or 17.08, or for outpatient emergency department data, as described in technical and data specifications issued by administrative bulletin pursuant to 114.1 CMR 17.15, and the hospital fails to submit satisfactorily corrected records within 30 days pursuant to 114.1 CMR 17.09(2) and 17.10(2); or

(b) the acute care hospital fails to submit the required data in accordance with the dates specified in 114.1 CMR 17.10.

## 17.12: Protection of Confidentiality of Data

The Division shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected thereunder are "personal data" within the meaning of that statute. In addition, the Division shall ensure that any contract entered into with other parties for the purposes of processing and analysis of data collected under 114.1 CMR 17.00 shall contain assurances such other parties shall also comply with the provisions of M.G.L.c. 66A.

The Medical Record, Medicaid Recipient, Billing and Unique Health Information numbers shall be used only for the purpose of establishing an audit trail in the event that it is necessary to retrieve the primary source document for validation of the abstract data and for linking case mix data and for linking case mix and charge data. The Division shall also ensure that data collected under 114.1 CMR 17.00 and redisclosed to other parties shall be purged of the patients' medical record and billing numbers, Medicaid Recipient Identification Number (Claims Certificate Number), Unique Health Information Number and date of birth prior to redisclosure except as required by 114.5 CMR 2.00. The Medicaid Recipient Identification Number shall be held confidential to all requesters with the exception of the Massachusetts Division of Medical Assistance except as required by 114.5 CMR 2.00. The Social Security Number will be held confidential to all requesters.

## 17.13: Severability

The provisions of 114.1 CMR 17.00 are declared to be severable and if any such provisions or the application of such provisions to any hospital or circumstances are held invalid or unconstitutional, such invalidity or unconstitutionality shall not be construed to affect the validity or unconstitutionality of any of the remaining provisions of 114.1 CMR 17.00 or of such provisions to hospitals or circumstances other than those as to which it is held invalid.

## 17.14: Administrative and Technical Information Bulletins

The Division may, from time to time, issue information bulletins to clarify its policy and understanding of the administrative and technical provisions of 114.1 CMR 17.00.

## 17:15: Outpatient Emergency Department Visit Data

### (1) General Requirements.

(a) Emergency department visit data shall be reported for all emergency department visits, including Satellite Emergency Facility visits, by patients whose visits result in neither an outpatient observation stay nor an inpatient admission at the reporting facility. ED visits that result in inpatient admission should be reflected in the report of the inpatient discharge and appropriately flagged as provided in 17.04(3) and 17.06(1)(k). ED visits that result in an outpatient observation stay should be reflected in the report of the outpatient observation stay and appropriately flagged as provided in 17.08(1) and 17.08(2), unless the patient is subsequently admitted as an inpatient, in which case the record should be reported as an inpatient discharge with the appropriate ED and observation flags. The outpatient emergency department visit data is subject to the same data submission arrangements, submission dates, compliance requirements, and data protection provisions as the inpatient discharge and outpatient observation stay data, and as specified in 17.09, 17.10, 17.11, and 17.12 respectively.

(b) Hospitals must submit outpatient emergency department visit data including but not limited to information on patient demographics, physicians, diagnoses, services, visit source and disposition, payment source, charges, mode of transport, and E-codes. Data must be submitted in accordance with Division technical and data specifications, which will be issued in administrative bulletins. The Division may revise the specifications or other administrative requirements from time to time by administrative bulletin.

(c) At the time of each quarterly data submission, hospitals shall report, on a form provided by the Division, the number of beds in the on-campus emergency department and satellite emergency facility on the last day of the reporting period, and, for the entire reporting period, the number of outpatient ED visits, the number of ED visits resulting in an admission to an outpatient observation stay, and the number of ED visits resulting in admission to inpatient care.

### (2) Outpatient Emergency Department Visit Data Quality Standards.

The data will be edited for compliance with the edit specifications as described in technical and data specifications issued in administrative bulletins pursuant to 114.1 CMR 17.15. The standards to be employed for rejecting data submissions from hospitals will be based upon the presence of Category A or B errors as listed in the specifications for each data element under the following conditions:

(a) All errors will be recorded for each patient discharge. A patient discharge will be rejected from updating the data base if there is:

1. Presence of one or more errors for Category A elements.

2. Presence of two or more errors for Category B elements.

(b) A hospital data submission will be rejected if:

1. 1% or more of discharges are rejected or

2. 50 consecutive records are rejected.

(c) Acceptance of data under the edit check procedures identified in 114.1 CMR 17.15 shall not be deemed acceptance of the factual accuracy of the data contained therein.

### (3) Historical Data

In addition to the quarterly data submissions for the reporting periods that begin on and after October 1, 2001, hospitals shall submit emergency department visit data for the period January 1, 2000 to September 30, 2001 according to the dates set forth in 114.1 CMR 17.10(1)(b). Data for each quarter in this period shall be submitted separately. Data submitted must be in the same format as data for the reporting periods beginning on or after October 1, 2001, and must be readable and usable by the Division; it should include accurate coded clinical, payer and demographic data. The Division will not require hospitals to collect data they do not have in their records for visits occurring during this period; however, hospitals shall submit all requested data elements that were stored in electronic records for those visits, which should, at a minimum, include information normally reported on claims. Hospitals must identify the data elements that are unavailable and the time periods for which they are unavailable. Data for this period will not be held to strict edit standards as described in the technical and data specifications for reporting periods beginning on or after October 1, 2001, although the Division may specify minimum edit standards for this data in an administrative bulletin.

REGULATORY AUTHORITY
114.1 CMR 17.00: M.G.L.c.118G.; M.G.L.c. 176A, s. 5.